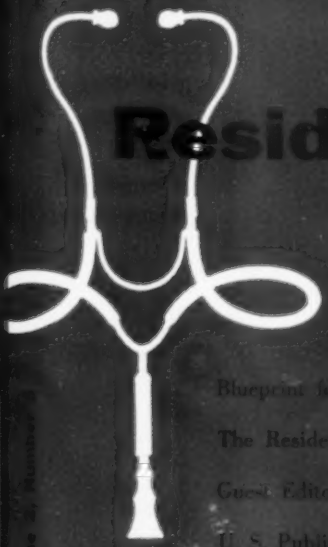

Resident Physician

May 1958, Volume 8, Number 5

Journal for the Hospital Resident

Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

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- nervous tension
- emotional stress
- food intolerances
- excessive smoking
- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastric pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

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1. Arnoff, B.: Personal communication. 2. Lazarte, J. A., and Petersen, M. C.: Personal communication.

Serpatilin Tablets, 0.1 mg./10 mg., each containing 0.1 mg. Serpasil® (reserpine CIBA) and 10 mg. Ritalin® hydrochloride (methylphenidylacetate hydrochloride CIBA).

Dosage: 1 tablet b.i.d. or t.i.d., adjusted to the individual.

Serpatilin T.M.

(reserpine and methyl-phenidylacetate hydrochloride CIBA)

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May 1956, Vol. 2, No. 5

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Resident Physician

May 1956, Vol. 2, No. 5

Articles

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Vitamin C (ascorbic acid)	50.0 mg.
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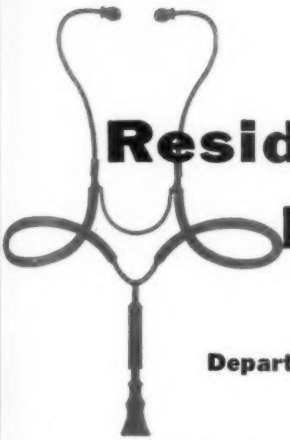

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Departments

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Journal for the Hospital Resident

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Articles are accepted for publication with the understanding that they are contributed solely to this publicaion, and will directly interest or be of practical value to resident physicians. When possible, two copies of the manuscript should be submitted. Articles with photographs, illustration or drawings are especially desired.

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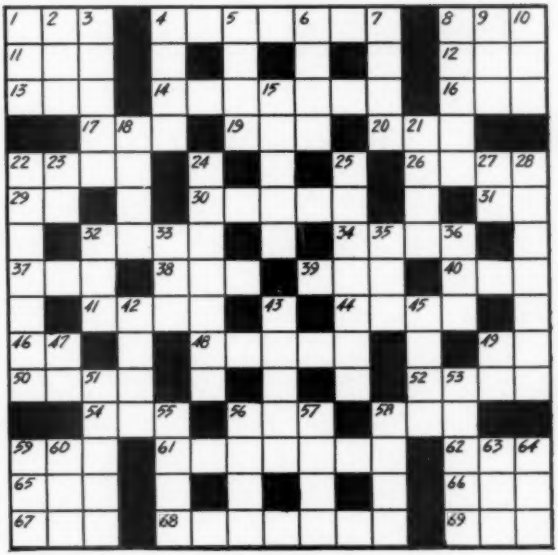
Resident Relaxer

(Answer on page 130)



ACROSS

1. Sick
4. Glucophospholipin found in the liver, spleen, muscles, blood and brain
8. In the past
11. In dentistry, a cast of the mouth over which is made the blank of artificial denture
12. New (prefix)
13. Abbr. for electroencephalogram
14. A furrow, fold, or crease in the skin
16. Number of digits on handgs of a normal person
17. An exclamation of delight or regret (Pl.)
19. Lixivium
20. A wreath
22. Festive
26. Abbr. for adrenocorticotrophic hormone
29. Before meals
30. Large pelvic bone
31. In proximity to
32. Popular inlay material (Dent.)
34. Olfactory organ
37. Visual organ
38. A suffix denoting that the element to the name of which it is attached is in combination in one of its lower valencies
39. A liquid of fatty consistency and unctous feel
40. Phenol source
41. A combining form meaning the back
44. A combining form noting defect of eye
46. Gr. ouron (urine)
48. Bone healing
49. Chemical symbol o actinon
50. A prefix denoting half or partly
52. To stare or eye amorously
54. Auditory organ
56. U.N.'s Health Organization (Abbr.)
58. Basal nomina anatomica (Abbr.)
59. A London surgeon noted for an operation overcoming fresh adhesions in the joints
61. Tube leading from the bladder
62. The lower extremity
65. The singular or reis
66. Pinna
67. American Dietetic Association
68. A nutritional disease of young birds
69. Upper limb

DOWN

1. A suffix denoting a binary chemical compound
2. To assume a position of rest
3. German physician associated with cephalaglia pharyngotympanica
4. Maxilla and mandible
5. Structure consisting of series of windings
6. Type of retractor fact of the eye (Co Form)
7. Belgian physiologis and otologist (1847 1920)
8. Ludicrous act
9. "To the right"
10. An egg, the seed of a plant
15. A prickiny, puncture
18. An areola
21. Organs of hearing
22. Pertaining to most rarified state of matter
23. Anodal closure (Abbr.)
24. Of two days duration
25. The membrane around the fetus (Pl.)
27. Abbr. of tubercle bacilius
28. The fundamental unit of water
32. A substance that produces, or generates
33. Fortune
35. Abbr. for occipitolaevo-posterior
36. A Greek letter
42. Denoting a kind of defect of the eye (Comb. Form)
43. Vision
45. Hematopoietic essential
47. Abbr. for right eye
49. Aluminum (Symb.)
51. The middle coat of an artery
53. Fascia over the skull
55. The gluteal region
56. A New York surgeon associated with appendicostomy
57. Unit of electrical resistance (Pl.)
58. Pouch or sac (Pl.)
60. One of the primary colors
63. Organ of hearing
64. Abbr. for gram

a "judicious combination..."

for antiarthritic therapy

SALCORT*

That cortisone and the salicylates have a complementary action has been well established.[1-5] In rheumatic conditions, functional improvement and a sense of feeling well are noted early. No withdrawal reactions have been reported.

One clinician states: "By a judicious combination of the two agents . . . it has been possible to bring about a much more favorable reaction in arthritis than with either alone. Salicylate potentiates the greatly reduced amount of cortisone present so that its full effect is brought out without evoking undesirable side reactions."[1]

INDICATIONS:

Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Bursitis . . . Still's disease . . . Neuromuscular affections

EACH TABLET CONTAINS:

Cortisone acetate	2.5 mg.
Sodium salicylate	0.3 Gm.
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Calcium ascorbate (equivalent to 50 mg. ascorbic acid)	60 mg.
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* U.S. Pat. 2,691,662

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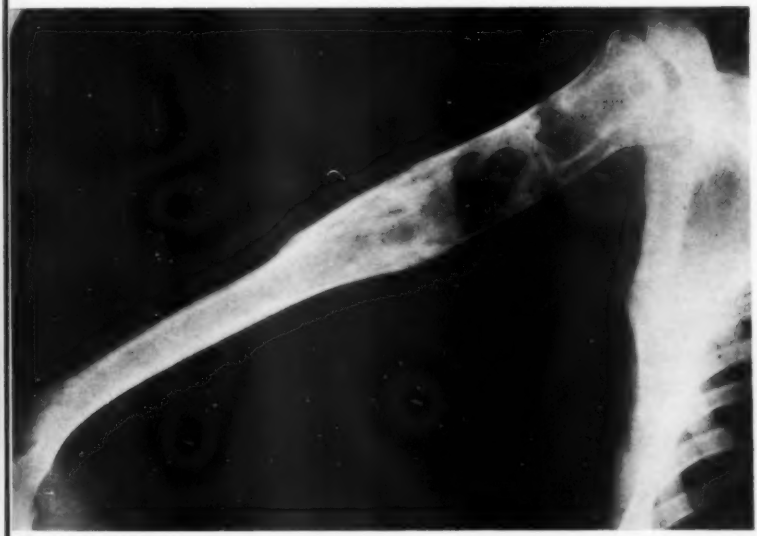
Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

Which Is Your Diagnosis?

1. Osteomyelitis
2. Giant cell tumor
3. Simple cyst
4. Myeloma
5. Osteochondroma

(Answer on page 130)



"... power over the motion of the heart..."

—William Withering

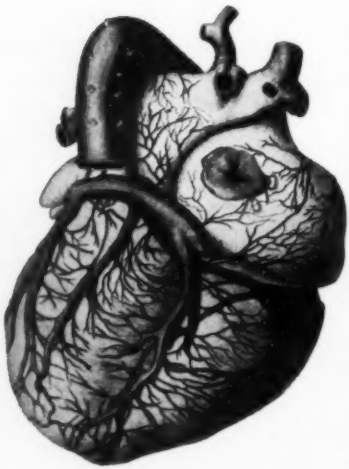


Illustration of a heart from Cloquet's "Anatomie de l'Homme," Paris 1850

Empirically, cardioactive drugs have served mankind for more than three millennia: the Ebers Papyrus (*ca.* 1500 B.C.) records the Egyptians' medical use of squill, and through the centuries substances prepared from various plants and from the venom or dried skin of toads have been used for their cardiotonic action. Digitalis itself was known as early as 1250; and in 1785 William Withering wrote down many still-valid principles in the use of this plant. He used it primarily for relieving dropsy, but did not associate this with the cardiac action of the drug, though he recognized that "It has a power over the motion of the heart to a degree yet unobserved in any other medicine,..."

Curiously, however, only within the past 40 years has it been clearly understood that the main value of digitalis is in the treatment of congestive heart failure. Even more recent is the isolation, purification and clinical use of the crystalline glycosides of digitalis, including Digoxin. Most of these can be assayed only biologically, but Digoxin may be assayed physicochemically; this degree of accuracy in standardization ensures uniformity of potency.

Digoxin provides optimal timing of action for oral therapy; prompt onset of effect plus constancy of absorption and a favorable rate of elimination give rapid digitalization followed by even maintenance. Particularly important is the significant margin of safety afforded by the quick subsidence of toxicity (after withdrawing the drug or reducing dosage) in the event of inadvertent overdosage. In emergencies, when an effect is required within minutes, 'Wellcome' brand Digoxin Injection has the practical advantage that it may be given either intramuscularly or intravenously and no prior dilution is necessary.

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'Wellcome'® brand Digoxin **ELIXIR PEDIATRIC** *0.05 mg. per cc.*

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Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request your name will be withheld.

Language Is THE Problem

I am a Turkish resident physician. I have been in this country for about two years. During this period of time I had opportunities of meeting foreign doctors from different countries, as well as American doctors. I had the chance to discuss with them a number of questions concerning different aspects of life here and abroad. Many times we thought about the condition of foreign doctors in U.S.A. But when I read the article of a Philippine-born doctor in the March issue of the *Resident Physician* I was rather surprised.

The main and the essential problem of a foreign born resident in America is simply his ignorance of the English language, and sometimes his reluctance to learn it. All his difficulties, discouragements and instabilities originate from the same cause. Medicine is a highly delicate, profound and complicated science and art. Language in its practice is of prime importance. This is a fact which should be very well understood.

An American doctor, generally speaking, is patient, interested in his profession. He has all the facilities to keep in contact with the progress of medicine, and he is anxious about that point. To keep pace with him, to compete and to surpass him, a foreign doctor, first, has to learn English. Thereafter he could begin to expand his knowledge and abilities; and continuing to work hard, he will observe that he shall be helped, praised and even admired. There are hundreds of foreign doctors working in the largest and most famous medical institutions in U.S.A. A look at a great number of university hospitals will demonstrate this.

The United States of America is a country where knowledge, effort and good will are always rewarded in the most democratic way. Talents and abilities are objectively and gen-

—Continued on page 24

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Because of its liquid form, dosage of SUSPENSION CHLOROMYCETIN PALMITATE is easily adjusted. That it needs no refrigeration is an additional convenience to every harassed mother.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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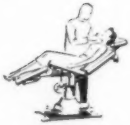

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in refractory heart failure

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Therefore, wherever digitalis therapy is indicated—

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Continued from page 20

erously acclaimed. Without showing these virtues nobody has a right to expect any respect and attention from his colleagues.

For a foreign born resident, a sound knowledge of English is the basis of success in this country. To learn a language depends on one's own will and perseverance. Anybody who cannot speak, write and understand English, while working in American hospitals, deserves the jokes and teasings and even the disapproval of his English speaking colleagues, and anybody, anywhere under the same circumstances, will be a similar target.

M. Erdal Ural, M.D.
C & O Hospital
Huntington, W. Va.

Getting Started In Practice

Here is a summary concerning a project we have in our department to aid our residents in planning for private practice. There are probably many modifications of the same thing around the country, but I thought this outline might be helpful to other groups:

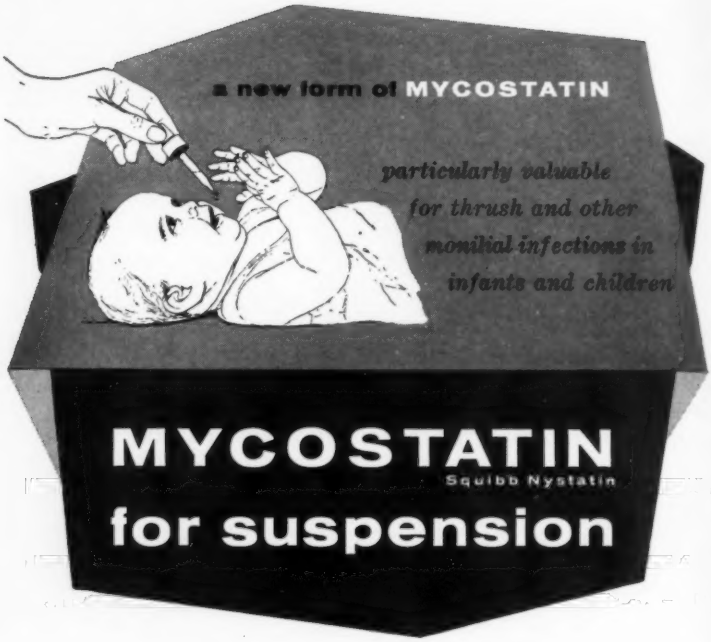
On a shelf in the Pediatric Residents' office at Duke lies a well-worn box labelled enticingly, "So you're going into practice?!" During the past three years, this has become a goldmine of information for the person organizing his office plans during the last months of his residency training.

Originated by Dr. Jerry Harris, Professor of Pediatrics, after observing the annual spring madness send his residents writing and roaming the countryside for helpful ideas, the file is now carried on by contributions from many sources. Inasmuch as each new pediatrician believes that his ideas are the most perfect, he is only too happy to leave a set of his procedures and plans for the next group.

A partial list of contents: Samples of office records (from completely self-devised sets to the standard forms supplied by Mead Johnson and the office supply houses), current catalogs of the major printing and office supply houses; booklets, folders, articles on office laboratory procedures; catalogs from office furniture companies in this area; check-list of supplies ordered by various persons in setting-up their offices; articles and reprints dealing with office planning, tax information, office assistants, etc. from such journals as *Medical Economics, Resident Physician, GP, JAMA,* and *Mead Digest;* plans for construction of various pieces of office equipment.

Frank P. Anderson, M.D.
Department of Pediatrics
Duke Hospital
Durham, N. C.

A system similar to the one described would certainly be of benefit to residents in every hospital. We hope all residents will give the idea serious consideration. Our thanks to Dr. Anderson.



The usual pediatric dosage for oral or intestinal moniliasis is 1 cc. dropped into the mouth four times daily.

When reconstituted by the pharmacist in 22 cc. of distilled water, each cc. of the suspension contains 100,000 units of the antifungal antibiotic, nystatin. 24-dose bottles, with dropper calibrated at 1 cc.

also available:

MYCOSTATIN Vaginal Tablets (100,000 units): packages of 15.
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for control of fluid balance

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Perrin H. Long, M.D.

Editor's Page

Responsibility For the Care of Patients

THOUGH these thoughts are directly related to the responsibility for patient care in a large municipal hospital, what applies to such a hospital, in general, applies to many hospitals in this country and should be of interest to resident physicians.

The director or superintendent of the hospital is generally responsible for the medical care and treatment of patients in that hospital. However, he shares this responsibility with the chiefs of the various services. The chiefs of service, in turn, share patient responsibility with their professional colleagues.

Thus, in any service, the house staff, laboratory and research personnel, and the attending staff must cooperate fully with the chiefs of service in order to fulfill the grave responsibilities attendant to patient care in the hospital.

It is obvious that in all but the smallest services, the chief cannot directly and constantly guide the treatment of each patient. The chief must delegate authority.

1. Authority for the *immediate care and treatment* of patients, or certain types of patients is delegated to the house staff of the service.

2. Authority for the *direction and supervision* of the care and treatment of patients is delegated to the attending or visiting physician or surgeon by the chief of service.

Final professional authority for the care of patients rests with the chief of service.

The distinction here is important. The director or superintendent of the hospital *shares* his responsibility with those concerned in the care and treatment of patients. But, authority *is delegated* to the

professional staff to provide the care needed by patients so that the hospital's responsibility may be fulfilled.

Defining this may seem like splitting hairs. But when the meaning of responsibility and authority are clearly understood by all, the hospital functions smoothly for the benefit of its patients.

It is important to the training of a physician or surgeon, that as much authority be delegated to the members of the house staff for the immediate care and treatment of patients as is commensurate with their intelligence, their training and their experience. An important item in this respect has to do with the writing of orders for the care of the patient. Whenever possible the writing of orders should be done by the intern and resident charged with the care of the patient. This should be adhered to, except in emergencies, if the treatment of the patient and the education of the house staff is to be carried out in an orderly manner.

From time to time, it will be necessary, in the best interests of the patient to ask for an opinion from a physician or surgeon, other than those immediately in charge of the patient, relative to diagnostic or therapeutic procedures for that patient. In getting this opinion or *consultation* (this is the word, not "consult"), it must be borne in mind that the process should result in a discussion between two or more doctors concerning the illness of the patient.

The object of a consultation is to bring the thoughts of two or more minds to bear on a problem or problems of illness in a patient. Too often, this does not occur. The consultant may rush in to see the patient, hastily scan the record, ask a few questions of the patient, do a regional physical examination, scribble a note (hopefully so) in the patient's record, and then depart. This type of consultative service almost always results in an *impression* — which helps the patient very little.

Another factor relative to the consultant's opinion has to do with its status. As the consultant is not in charge of the patient, he acts in the capacity of an *advisor*. The physician in charge of the patient may or may not accept the consultant's recommendations. That is not only his privilege but his duty.

Sometimes two or more consultants see a patient and there is disagreement between them. If this occurs, it is the duty of the physician in charge of the patient to get the consultants together and try to resolve the disagreement. But if this is not possible, the final decision on what is to be done is up to the physician in charge.

Now, a word to residents relative to consultations. Do not attempt to use the consultant to bolster up or to flaunt your own diagnostic or therapeutic acumen. In other words, use the consultant according to the needs of the patient or his family. You must always bear in mind that you may ask for help when you are puzzled, and the patient or his family have a similar and overriding right to ask for another opinion when they are puzzled by illness. So make the best use of consultants.

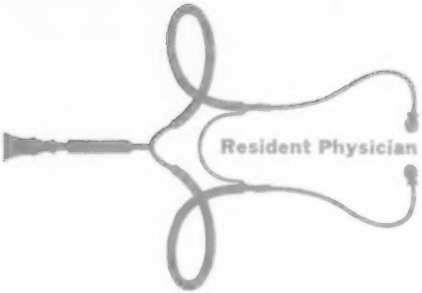
It has always appeared to me imperative that clinical investigations of illness be carried out if the best interests of the patient are to be served. However, in order that the greatest benefit may be derived by the patient and all concerned from clinical research and investigations of his illness, the following stipulations should be borne in mind:

1. The patient and the house staff caring for the patient will be thoroughly apprised of the plan for investigation.
2. The plan for the investigation will be discussed with the attending physician or surgeon who is in charge of the patient.
3. Data derived from clinical investigation will be incorporated promptly into the patient's case record.
4. If the patient has to be removed from the ward for the procedures of the particular investigation in progress, i.e., cardiac catheterization, studies of pulmonary function, ballistocardiography, etc., *the physician conducting the studies* will be charged with directing the care of the patient while the latter is away from the ward. When indicated, he will also advise as to the care of the patient for the next twenty-four hours or more after the patient has returned to the ward.
5. All clinical investigative plans and procedures will be cleared through channels and in writing with the appropriate authority in the hospital.

If these stipulations are observed the rights of the patient will be safeguarded; both the house and attending staffs will be satisfied and the investigator will reap the benefits that attend cooperative effort.

I hope I will be seeing many of you in Chicago at the A.M.A. Convention.

Perrin H. Long.



Blueprint for Better Conferences

Conferences are too important to your training to ignore your part in making them work. Good conferences require organization, advance planning and publicity

All conferences, whether case presentations, CPC's, slide sessions, demonstrations or rounds, can be major elements of your hospital training. Each should be an event. An opportunity to recharge your medical thinking.

Too often, the average conference is short-circuited by sloppy organization, poor scheduling, lack of enthusiasm in the presentation or weak medical content. Some are a waste of time. And your time, the hospital's time, the time of attendings and professors is a most precious thing in any hospital residency program.

You are directly involved. You can do a lot to make conference time count, tighten up your conference schedule, aid in making the arrangements for good conferences, properly presented.

Your authority

When hospitals have an educational committee to plan and coordinate programs of lectures, conferences and rounds, all activities, including intra-departmental ones, should be cleared by this committee. The educational committee usually appreciates comments and suggestions from the house staff.

Usually, the chief of service is responsible for setting up conferences. In most cases he delegates authority to the chief resident. It then becomes the job of the resident to see that the conference goes well.

Good conference

But good conferences don't just happen. They require careful planning, effort and cooperation from many sources.

A good conference must be educational. But to make education "take," it must be lively and interesting in its content, organization and presentation.

A good conference requires close attention to what may seem minor details of management. But these details often determine the value of the conference to all concerned, attendings, house staff and patients.

Now, a closer look. What are the elements of a well run conference?

1. Scheduling
2. Speakers and discussion
3. Presentation and demonstration
4. Attendance

Time schedule

Quite obviously, the time of the conference or lecture or special rounds must be arranged so that the majority of those expected to attend can do so.

Since a number of busy doctors (including residents) are involved, the schedule is your number one problem. The first requirement for solution is to list the individual time schedules of each of the attending physicians on your service. In some of the larger hospitals, this can be a formidable task.

Fortunately, many chiefs of service have a timetable which you can utilize. Those not having such a list can arrange with the department secretary to work one up for

your use in planning a conference schedule.

Next on your list (you're well on your way now to becoming an *administrative* resident, par excellence) is a timetable of the house staff. As with the attending staff, this must be of a general nature since patients' needs determine the course of any one hospital day. But even a general schedule is more helpful than no schedule.

Conference calendar

Now, you're ready to set up your conference calendar. A manila folder will do. Simply list dates and days of the month in the first column (some hospitals break it down into morning and afternoon sessions, too) and across the top indicate the type of conferences and meetings you might be having for that month. Line off the columns, horizontally and vertically.

Next, knock out all holidays and also indicate any hospital-wide activities already scheduled which would conflict with your conference plans.

Now you're ready to sit down with your chief and work out a tentative plan. By considering the house staff duties such as ward rounds, outpatient clinics, operating room times (perhaps no mornings can be considered "available" until eleven o'clock or later) and other parts of the house staff daily routine, you will isolate certain dates and times when maximum attendance can be expected. And that's what you're shooting for.

Keep in mind that nothing is more difficult than holding a conference which is permitted to extend into the house staff's lunch hour or overlaps into the starting time of outpatient clinics. Similarly, a conference held during office hours or attendings' "day off," will gain very poor attendance from the visiting doctors.

Of course, it will invariably happen that the time suited to some will be poor for others. But since the conference is important to the house staff as well as to the visiting men, both groups will make an effort to be there.

Conference length

By custom, the average conference in most institutions is scheduled for a one-hour period. This seems to be about the right length of time to be able to hold a group's attention.

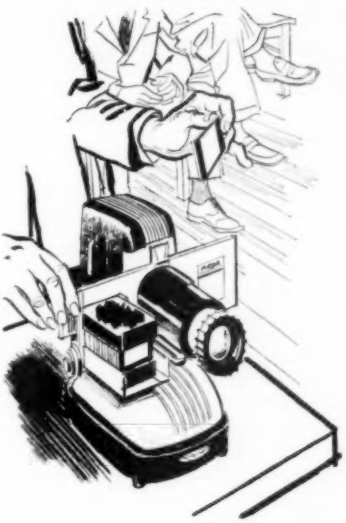
It is very important to start a conference *on time*. It is equally important to end it at the set time. There is rarely any valid excuse for a conference to run an hour and a half, if it has been scheduled for one hour. By the same token, don't allow your conference to start at 2:10 p.m. if it was scheduled for 2 p.m.

Avoid interruptions

Once the meeting is underway, the doors of the conference room should be closed. Most of your latecomers

will soon get the idea and begin showing up on time.

All who attend the conference should know they can be reached in an emergency. Messages can be taken at the door by an intern delegated to this task. The intern can simply write the name of the doctor on the blackboard and the doctor thus notified can slip out of the room without undue disturbance of the conference.



Speakers

The person invited to speak, whether a member of the house staff, attending staff or a guest speaker from outside the hospital, should receive advance notification as to time, place and probable size of his audience.

If you invite a guest speaker, he will choose his own topic from within the framework of the subject he has been asked to discuss.

It is both a matter of tact and professional courtesy to inform the speaker and the moderator as to the expected attendance of any well-known authority on the subject to be discussed.

Be certain to reach an agreement with the speaker regarding the length of his talk; find out whether he would like to have a question and answer period follow.

In many conferences a number of people are involved. First, all cases to be presented should have the O.K. of the chief of service. Second, the chief will want all doctors participating in the care of the patient (roentgenologists, pathologists, attending physicians, etc.) to be notified and requested to appear at the conference. This will give these physicians an opportunity to review the patient's record beforehand.

Discussion

It is important to remember that any didactic presentation of clinical material in the form of lectures on appendicitis, pernicious anemia, lobar pneumonia, etc., should be avoided. This information is available in current textbooks.

When lectures are planned they should cover recent research, areas

of disease, and if possible, should be given by someone who is actually working in the field, not just reading about it.

Since the "meat" of a conference often comes out of the discussion which follows, a definite period should be scheduled for this.

Discussors sometimes forget that they are not supposed to parrot textbook descriptions of diseases, but should discuss the effect of the disease and its treatment on the patient in question. Anyone can read a book.

Discussors should be brief. Others will want to say something.

It is wise to have the chief of service lead the discussion, rather than leave it to a speaker, who may or may not know his audience, or who may be so carried away by the sound of his own voice that he will take the remainder of the conference time. Also, the chief might know those apt to ramble and digress at length and those who generally introduce stimulating and challenging material.

Presentation and demonstration

Indispensable to many types of conferences are the patient's records, the chart and an abstract of the patient's history.

Sufficient copies of the abstract should be distributed before the conference begins. When possible, a copy should reach invited speakers well in advance.

An abbreviated summary of the history, if written on the blackboard just prior to the conference, is often helpful to the audience. Usually, an intern or resident will go over the material during the conference.

One rule: The resident presenting the case should always speak distinctly, facing his audience, and delivering the material with the assumption that everyone wants to hear what he has to say. No mumbling or turning to face the blackboard.

Foreign residents (who may have a slight to heavy accent) should remember to speak at a moderate rate of speed without any attempt to rush their presentation.

What you have to say *is important*. Make your audience know it.

Slides are valuable

Properly prepared slides, charts or other visual exhibits make difficult material easier to assimilate. But selection is important. The material chosen should educate your audience rather than impress it.

All visual material should be readable from the back of the conference room. Charts should be simple, concise. Slides should have good contrast, be kept dust free and *in focus*, and clearly demonstrate the point in question.

Frequently the guest speaker will bring his own lantern slides or display material. It is important that the proper type of projector is available in the conference room,

together with a suitable screen in a good location for all to see. (An adapter may be needed to accommodate certain slides to standard projectors.) Slides should be arranged in proper order for presentation before the room is blacked out.

Other materials

If x-rays are to be shown, make sure a viewbox is "on location" and an outlet is available.

Too many chairs never hurt any conference—although the audience should be directed to the front rows first. Too few chairs will cause discomfort, confusion and delays while other chairs are brought in.

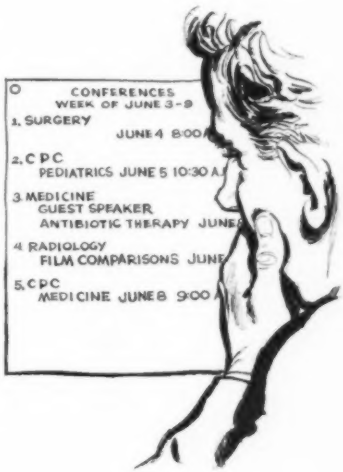
Keep attention

Proper ventilation of the conference room is a must. Perhaps the single failing most common to conferences is diminishing attention as the conference progresses. There are many causes; but the easiest one to correct is permitting the circulation of fresh air. Any resident who has been called from his bed two or three times the evening before the conference will certainly appreciate this point. (There is something about a Spring afternoon in a crowded, stagnant, conference room that would have even an insomniac burying his chin in his chest.)

Patients presented

The presence of a patient at the conference always adds interest and spurs attention. Yet, don't make the mistake of presenting a patient with "an almost cured case of lobar pneumonia" or some such. This will produce boredom in the conference, waste the time of all physicians present, and disrupt hospital and nursing routine to no good purpose.

Patients should be present only



if they have findings of interest to demonstrate to the conference group. Diagnostic problems or a therapeutic puzzle are proper reasons for a patient's presence. When a patient is presented having a heart murmur, it is not necessary for an audience of fifty to verify this fact. One or two can examine the patient. Others may see the patient on the ward if they desire to do so.

Attendance and publicity

Often, the large conference audience stimulates the individual's contributions. In addition, a wider assortment of professional experience is available to bear on the discussion or take part in the question and answer period.

Any series of conferences which has established a reputation for being well run and lively will generally draw a heavy attendance from house and attending staffs. Conferences known to be dull usually play to empty seats. Those in attendance are disinterested (many are there only because they are expected to be there) and the conference itself is of little value to anyone.

So, as a general rule, if you make your conference a good one every time, word will get around. Attendance will be no problem—except perhaps the need for a larger hall.

But even the best conferences need some publicity. Some hospitals mail conference schedules to their attending staff. Some have conference programs published in local medical society bulletins. The bare minimum should be to publish the title and time of each conference on the hospital bulletin board at least one week in advance of the meeting.

And finally, a departmental conference should be publicized

"I'm almost sorry I asked the chief to speak louder."

throughout every department and service in the hospital. The subject or patient involved in a urology conference, for example, might well be of great interest to the general surgical service, internal medicine residents or any number of other groups within the hospital. This "open invitation" idea, though often implied, is now coming to be more publicized. Date, place, time, speaker, subject, and the nature of the planned presentation is usually included in a hospital-wide notice sent to all department heads and chiefs of service in the form of a "Conference Notice."

Mixed conference

Special inter-departmental conferences can be held when a patient has moved from one service to another during the course of his hospital treatment. This type of conference is always well attended and inevitably creates a great deal of interest.

There is no need for any service to hide its educational light under a barrel. All residents are physicians before becoming specialists. And many benefits come from crossing specialty lines.

Mixed conferences broaden each resident's medical view, give him experience in viewing the sick through the eyes of other specialties than his own and offer him a background from which he can treat the patient as a whole, having many vital but completely integrated parts.

All conferences are not good conferences. They should be. And with a little planning, you can make them so.

Ophthalmology Fellowships

Providing financial help throughout a three-year residency period, a plan calling for eighteen fellowships for residents in ophthalmology has been sponsored by the Guild of Prescription Opticians of America.

Six fellowships, each worth $1,800 ($600 a year, for three years, payable monthly), will be awarded each year beginning with the current year.

Fellowship awards will be made on a regional basis, one award to be made annually in each of six geographical areas of the United States and Canada. Area divisions were drawn so that each region has approximately the same number of three-year ophthalmology residencies available. Applications may be obtained from the Guild headquarters, 110 E. 23rd St., New York 10, N. Y.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The Resident in the Used Car Market

How do you separate the clunks from the cream puffs? There's only one sure way. Give anything your interested in a real examination and work-up. Don't leave out any tests

THE FIRST part of this article on used cars appeared in the April issue.

Get yourself within looking distance of any used car lot on a sunny day and the chances are you'll be blinded by the dazzle.

Everywhere you look you'll see brightly polished chrome, sparkling windows, gleaming paint.

In fact, it's pretty tough to tell the vintage chassis from its more recent cousins.

Nobody needs to tell you the reason for all this spit and Simoniz. It's obvious the men that run these establishments are interested in making sales.

Psychologically they've got two good jumps on you: First, you are interested in getting a car or you wouldn't be hanging around; second, all the cars you see *look* terrific.

So put on the blinders and break out the diagnostic set. You are about to give some of their specials a going over—but good.

Standing inspection

There are a lot of points you can and should check on a car before you ever start the motor. And you'd be wise not to leave out a single step on any car you look at; it won't take long. The dealer may offer to correct anything you find wrong or reduce the price accordingly. That's all in your favor.

So don't be afraid to get your hands dirty. Really check the car out for things which you can easily spot—and which usually would mean extra cost for you if you bought the car.

Tires

Worn tires are not too important. But the type of wear can be. Uneven wear can mean unbalanced wheels (balancing job: $1.00 per wheel plus change for wheel weights if needed) or complete misalignment of the front end. Realigning a front end is an expensive proposition. More important, the need for re-alignment may mean the car has been in a serious wreck. If you find this, reject the car immediately.

No matter what you may want in a car, safety is at the top of your list.

If all four tires are worn about the same, you can relax. Remember, though, the dealer may have switched unevenly worn *front* tires to the rear to conceal misalignment of the front end. So, check for uneven wear on rear tires, too.

Figure $15 to $30 per tire for new ones. Actually, tire experts say that good retreads will last you as long and are just as safe as new tires—assuming the "shoe" or tire carcass is undamaged. One way the dealer can cover sidewall imperfections is with special tire paint.

Rust

Indications of car wear and treatment can come from close inspection of rust spots around the trim and in the car's body metal.

A repaint job will cost $35 to $75. Another spot to check is at the base of doors and door posts. Solid steel should meet your probing finger, not rust holes. Check to see if these areas have been recently repainted or covered over with plastic to hide them. Any permanent repairs here would be expensive.

Paint

On the door weather-stripping is a good place to learn if the car has been repainted. Door hardware and upholstery (installed after the factory paint job is completed) also may indicate a repaint job. On a low mileage car, this is often a clue to either commercial usage or an accident.

Other telltale marks of a car that has been in an accident are the doors, the hood and car surface.

Sight along the flat surfaces of the car. See any waves or wrinkles?

Check the hood for perfect fit.

Open and close all doors. Note particularly whether a door drops slightly as it's opened. Sprung doors are a good sign that a car has taken a terrific smack or a rolling over.

Inside the car

The first thing the dealer will do when he gets in a used car is to give it a thorough cleaning. Then, depending upon the dealer, he will spend a few dollars to shine up the interior of the car.

If the floor mats are new or freshly painted, this has been done not to make you happy but to hide signs of wear. New seat covers on a used car generally mean the upholstery is shot.

The driver's seat is a good place from which to examine the car closely. If the car is fairly new and there's *badly* worn upholstery on the driver's side, it could mean hard commercial usage (taxi, salesman's car, etc.).

If the foot pedals are nice and thick, chances are the original set has been replaced.

You can take a glance at the odometer (the thing which records the number of miles) but it's seldom a clue. Check the door edges or under the hood for recent stickers indicating servicing. Usually these will include the mileage and the date. With a little figuring, you can sometimes arrive at a fair estimate of the mileage on the car. Like other signs, however, this is hardly ever infallible.

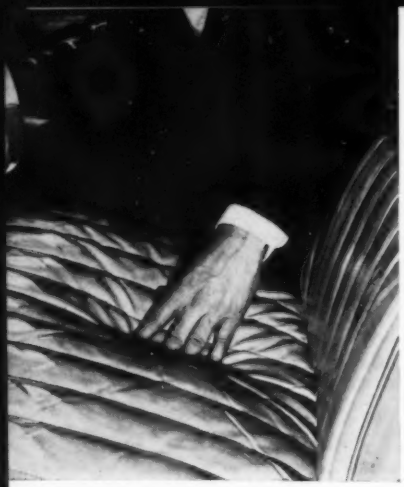
Steering

Wear on the steering wheel means mileage and something else. Severe steering wheel wear might indicate the car wanders (front end alignment again). If there is a wheel cover over the steering wheel, lift it up and look underneath if you can. Sometimes you'll find a fancy tape wrapped around the entire wheel. Its only job is to hide wear.

Turn the wheel right and left gently. See how much "play" there is. One to two inches free play in the steering wheel is generally safe. If there are more than two inches play in the wheel, it is dangerous—and will be your expense to bear for repairs.

Bumpers

Another indication of hard usage is bumper wear. Normally, any used car will have scratches or nicks on the bumper. But if there are severe digs in the bumper steel (not



simply the chrome) the car probably has been mishandled. If the bumpers have been covered with a chrome paint to make them look like new and any little nicks and dents around the body are also touched up, be extra careful. When a car has been doctored, it will test your ingenuity to determine its underlying condition.

Worn shocks

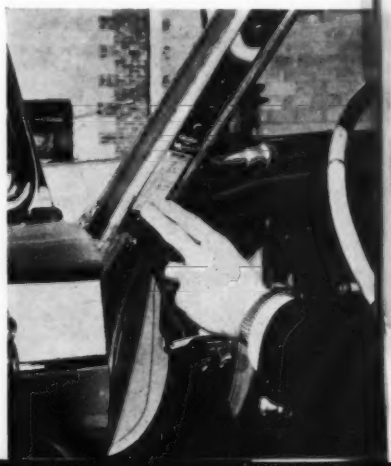
With a car on perfectly level ground, push down sharply on each corner of the front and rear bumpers. Or stand on the corner of the bumper and jump to the ground. A firm return of the car to its original level is what should occur after your weight is removed. If the car continues up beyond the level point and back down again, shocks are worn and will have to be replaced by you.

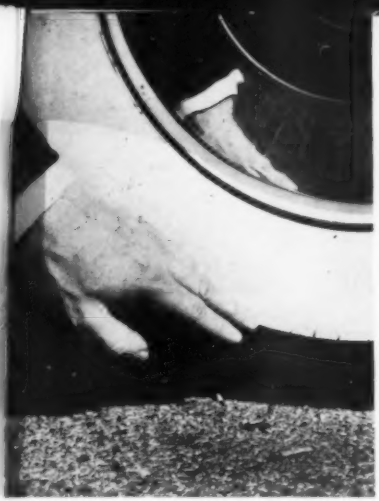
A low corner may indicate a broken spring. Worn shocks cause a front end to dip and dive when stopping or riding over bumps. At high speeds this can be dangerous. Shock absorbers will cost $25 to $40. Rear springs about $25. You needn't reject the car because of this but be prepared to pay for repairs.

While you are examining the front end of the car, check each of the front wheels in turn for bearing wear. Simply shake the wheel, alternately pulling and pushing with either hand. A half inch of play is okay. Any more than that is a sign of trouble, either bearings or king pins. It will cost to have it fixed.

Under the hood

If the motor hasn't been steam-cleaned, you can tell if it's been well cared for. (Don't listen to any stories about engine overhaul.) Check for signs of leakage, any-





where, whether hose connections or top of the block or under the block and even at the base of the radiator. (Be sure you re-check for leakage after the road test.) If the battery, terminal posts, and cable connectors are covered with corrosion, it's a good sign of an unhealthy and poorly maintained battery. This also may indicate poor maintenance.

On the road

Start the car. If the engine is hard to start, idles noisily or roughly, the engine may need a tune-up ($10 to $25) or a major overhaul ($100-$300). Of course if the engine barely turns over when you step on the starter, either your battery is low or shot or the starter motor is faulty. Once the car is running, check the exhaust. If the exhaust is clear or white steam, fine. If there is black smoke, a tune-up may cure the trouble. Bluish smoke may indicate the need for an engine overhaul due to long, hard wear. Pistons, rings, cylinders, push rods, valves, etc., all may need replacing. Expensive.

Radiator

Unscrew the cap on the radiator. Look for bubbles or an oily scum. This could be minor such as a leaky head gasket or it could be major, a cracked block. The latter would be reason enough to reject the car immediately, whereas flushing the radiator and renewing a head gasket may cost only $10 to $15 (vs. a block at $200). Check the outside of the radiator core if you can. If you find traces of white lime, it means previous radiator leaks. Any water at all on this core could indicate a leak is present. Radiator repairs are from $15 to

$50 depending on what's required.

Exhaust system

With the car in neutral, step on the gas and let up quickly. Any hiss or roar from the exhaust system could mean a burned-out muffler or a corroded exhaust. This is important. The risk of carbon-monoxide poisoning is one which you don't want to take. The cost of a muffler and exhaust pipe will run from $15 to $40 depending upon the make and model.

Bearings

Now for a bearing check. (Maybe you'd better wait to get out of the lot for this one since the dealer might flip if he sees what you're doing.) Putting one foot on the brake (in a car with automatic transmission), shift the car to drive and gradually increase the pressure on the accelerator. You're not trying to move the car; you're simply trying to put a load on the drive system.

Loose and worn connecting rods will sound like heavy stakes knocking on wood.

A worn main bearing will cause a sharp, heavy thump.

Now, take a look at the water temperature. If the reading has topped 200, there's something wrong with the cooling system. This may mean a worn fan belt, a faulty water pump or clogged radiator. The latter two can be expensive to repair.

Universals

With the engine running, shift the car from first to reverse and back again to rock the car. Any chunking sound in the rear-end could indicate worn universal joints. Repairs can run as high as $50.

Clutch

If your car doesn't have automatic transmission, press the clutch pedal by hand. It should have a ½" to 1" free play, before it meets resistance, that's all. No play means a worn clutch. Excessive play makes shifting difficult. Clutch adjustment costs only a few dollars but clutch relining or replacing may run $35-$60.

Brakes

Check the brakes before starting out. Push the pedal down by hand, it should move only about one-half inch before meeting resistance. If it goes half way down or more, the adjustment is faulty or there's a lack of fluid. Don't even drive the car if you run into this.

Now you're ready to move out with the car. Test the brakes again gently as you move out. There should be no sag when you press the brake pedal firmly. Pedal should stay firm when not more than half way down. If the pedal sinks slowly as you hold the pressure on, it may mean a hydraulic leak. Stop right there and don't take the car any further.

If the pedal is spongy and requires pumping, it may mean air is trapped in the system.

Have someone drive the car away from you and you stand behind and check to see if the car tracks properly. On some models, rear wheels will be slightly inside or outside of the front. However, they should follow a parallel track without being off-set to one side or the other. If they don't track properly, the car may have a broken spring bolt or shifted rear spring or axle. Also, the car frame may have been bent through collision.

Road test

Don't spare the car or baby it during the road test. How does it handle? Drive enough to get the feel of the strange car; get used to the way it handles.

Try to find some rough roads, hills and dirt roads if possible. Feel for any looseness in the steering wheel. This could mean minor tightening up process or it might require major gear replacements in the steering gear-box. If possible make your first driving test without the dealer or salesman along.

If you like the car but find something you don't understand or hear something that you can't interpret, it might be best to return, pick up the salesman, ask him to fix that particular item before you buy the car.

Turning

After you've gotten the feel of the car, find a clear, *level* stretch of road. At 15-20 miles per hour, remove your hands from the wheel. The car should move along 300 or more feet without drifting more than a couple of feet to either side. (Remember, the wind may affect this test so allow for it.) On a wide street without too much traffic, check the turning radius of the car. Make sure the wheels don't bind at any point while you make a slow, tight turn.

Now turn several corners in both directions and at varying speeds. The wheel might be a little stiff but it shouldn't bind at any point. It should return to center easily when released as you straighten out.

Now pick up the speed and try a few turns. Does the car dive to one side on fast turns? It should not sway excessively and it shouldn't "bottom," that is, tip down with a thump as you make a turn.

Hands-off test

Now back to the brakes again. (Remember, don't be easy on the car. If you want anything to break

down you want it to break down before you buy the car, not after.)

Try the hands-off test at a slow speed as you apply the brakes. Be sure to brace yourself and don't make an emergency stop and go through the windshield). The car should not pull or swerve.

Make three or four stops (from 45 to 50 miles an hour) in rapid succession. It should not become more difficult to stop the car at each successive braking. If it does, this would indicate the car has excessive brake fade (caused by heat on the brake linings).

If your car has a clutch, draw on the emergency brake while you're moving slowly. As the car comes to a stop, accelerate and pull harder on the emergency brake. When the car stops, the engine should have stalled.

If your car has an automatic transmission, stop on a hill, put the transmission in "Park." The car should not move. On a level, put the same car in neutral. There should be no creeping with the engine running.

As you start moving a car having automatic transmission, the engine should not race as the car shifts through the various speed ranges. There should be no thump or jerk in shifting up and down through the ranges. Go from a standing start to 50 and 60 a few times with full throttle. The car should *not* bunch its shifts in a ten or fifteen mile an hour range of acceleration.

Put the car in reverse just to make sure the reverse gear is operating.

Other points

If the car idles too fast it may mean that the car has been "set up" to hide a rough engine. If the car leans or heels to one side, this points to shock absorbers or a broken spring.

If the car doesn't pass all these tests, make a note of what's wrong. Discuss it with the dealer. You want

everything in order before you buy the car.

If the car stands up well through all these tests, bring the car back in and ask to have it put on a hoist for the final inspection.

As you turn off the engine, check the heat gauge. By this time any difficulties in the radiator should have made themselves apparent in the water temperature.

On the rack

While the car is on the rack, take a look at the master brake cylinder. If it shows signs of leaking, you will want either a new master cylinder or a new gasket.

Check underneath the engine for leaks of any kind, whether gas or oil. A gas line can be replaced, carburetors can be repaired. But why at your expense?

While on the hoist, check for signs of a sprung or welded frame. This automatically means the car is a bad buy.

Check under the transmission for oil leakage; check the differential (at the middle of the rear axle) for the same thing.

When the car is down from the hoist, have the wheels pulled so you can inspect the brake linings and wheel cylinders. If you find fluid behind the rubber caps on the

brake cylinders, early overhaul of the hydraulic system is indicated. This can run from $20-$40.

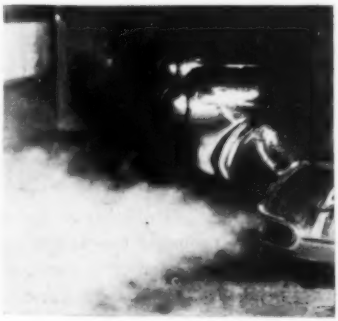
Check the linings to see if they're worn. If they are badly worn the rivets may have scored the brake drums. Brake overhaul and relining will cost from $25-$60 depending upon whether the drums have to be machined or "turned down". Check for leakage from the grease seals on the front wheels.

Rear axle check

Any oil around the rear axle shaft nut or at the bottom of the rear wheel brake backing plate means this oil will soon be, if it isn't already, on the brake lining, a dangerous condition. Oil leaks are easily correctible (between $6-$12).

Other items

Things to check are headlights (both low and high beam), taillights, horn, stop lights, back-up



lights, windshield wiper, radio, heater, blower, defroster, clock, and cigarette lighter. If any of these aren't working properly, they should be repaired by the dealer prior to your signing the purchase contract. Minor items, if not fixed, should bring you some concession on the price of the car.

Repairs vs. price

Now, in conclusion, no single defect may mark this car out. The price may have already allowed for it. In other words, you may have to pay for certain repairs. If the repairs are minor and the overall price of the car is quite low, you may still have a bargain.

Go slow

Shop around. You'll find something different in every lot and you'll learn plenty by spending a few hours checking out cars. Besides it's fun. However, don't get carried away or be talked into an expensive model which would make your monthly payments a budget-breaker. After all, you're only buying transportation —not a lifetime investment.

Also, if you haven't already thought about what it costs to own a car, take a peek at the table on "car ownership expense."

Expense

In any estimate of whether or not to buy a car, probably the first thing you should consider is the cost of car ownership. This is a question that has been argued over and over. If the accountant takes a look at the car's cost in dollars per year, he comes up with one set of figures. If you make an off-hand statement of what it costs to own and operate a car, chances are your figure would be a lot less than the accountant's tabulation.

As an approximate figure of what it might cost you to own a used car based on repairs, maintenance, gas, oil, tires, license, insurance, depreciation and parking expenses, this table may prove an eye-opener to you. Depreciation is probably the most difficult item. You can look back and be able to tell how much a car did depreciate; but to look ahead and tell how much it *will* depreciate is often just wishful thinking. (Trends have a way of changing just when you begin to depend upon them.)

Our table is based on a three year-old automobile running its fourth year under your ownership. By the fourth year, depreciation has leveled off. The first two to three years the depreciation on a car is heavy: 25% and more of the original purchase price the first year; an average of 20% for the second year, and around 10% the third year. Fourth and fifth years of depreciation would probably be 5%-10% of its original price. (At the end of its fourth year of operation, total depreciation would be somewhere around 60%-75% of its original new car cost. This of course

would vary from make to make.

Let's say the original new price on your car was $2800. You paid $1250 for it as a three-year-old. Therefore your depreciation in this, its fourth year of usage would probably be close to $200 or $250. That's your initial item of expense.

Car Ownership Expenses

Estimate based on a 1953 car (in medium price range) to be operated 8,000 miles from June, 1956 to June, 1957.

Depreciation	**$250**
Operating Cost	
gas, oil, tires, lubrication, maintenance	**$280**
Insurance	
bodily injury, property, collision—$75 deductible, comprehensive	**$105**
License fee	**$20**
Parking	
garage, meters, fines	**$25**
Total cost of operation (12 months)	**$680***
Monthly cost of operation:	**$57**

This, of course, does *not* include any monthly payments you may be making toward the purchase of the car. Excluding depreciation, your actual monthly cash outlay for operating your car would approximate $36 a month.

**About 8.5 cents a mile.*

By David J. Zaugg, M.D.

Guest Editorial

Over the years, residency training in medical specialties at federal hospitals has added appreciably to the nation's medical competence and has furthered the goals of the agencies that maintain health and medical care establishments.

The U. S. Public Health Service Hospital, Baltimore, Maryland, offers residency training in surgery, internal medicine, ophthalmology and otolarnygology, pathology, and radiology. These activities are part of an integrated program conducted by the Public Health Service at several of its hospitals mostly located in major port cities of the United States. Coordinated by the Internship and Residency Training Committee, the chairman of which is on the staff of the Chief, Division of Hospitals, these post graduate medical training efforts provide a steady stream of qualified specialists to discharge

responsibilities in medical care, public health and medical research. Clinical knowledge gained through instruction and experience in the hospital is often a major background qualification in medical pursuits separate and apart from direct care of patients.

David J. Zaugg, M.D.
Medical Director
Medical Officer in Charge
U. S. Public Health
Service Hospital
Baltimore, Maryland

Free exchange of ideas is one of the important features of training in the Public Health Service. It is gained by affiliations with our great university teaching centers, association with physicians from all parts of the United States, cooperation with community health facilities, and through the formally organized Clinical Society of the Public Health Service.

Our efforts here at the U. S. Public Health Service Hospital in Baltimore are only a segment, but an important part, of a total program covering the entire field of medicine as we know it today. The results can only be measured in terms of the leaders and leadership developed. In any dynamic organization, moving on into fields unknown, "Success is never final, failure is never fatal. It is work, patience and courage that count."

* * *

The U. S. Public Health Service Hospital at Baltimore is proud and honored to have been selected by the editors of *Resident Physician* for its feature in this issue.


U.S. MARINE HOSPITAL

U. S. Public Health Service Hospital at Baltimore

The U. S. Public Health Service Hospital at Baltimore is one of sixteen Public Health Service hospitals in the country. Most of the patients are American and foreign seamen, officers of the U. S. Coast Guard, U. S. Coast and Geodetic Survey and Public Health Service and their dependents, and federal employees injured at work. It has an approximate bed capacity of 360 and offers approved residency programs in internal medicine, surgery, radiology, pathology and ophthalmology-otolaryngology.

It is located in the Wyman Park area, adjacent to the Homewood campus of the Johns Hopkins University. Accommodations for staff living quarters on the station are limited in number, but suitable housing arrangements can be readily made in the vicinity. Recreational activities are organized largely through the Officers' Club, which is located on the station grounds. Organized dances and parties are held throughout the year. In addition, the Wives' Club affords a means of introducing newcomers to the community and sponsors various social activities for the ladies.

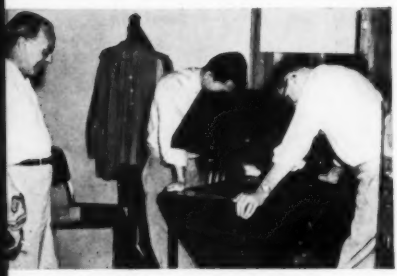
Job opportunities for the resident's wife are quite limited within the hospital itself, and are more likely to be available elsewhere in the city.

The hospital maintains an active medical library and full-time librarian. Although the intramural library facilities are limited in comparison to university standards, an active exchange program with medical libraries elsewhere in the city has been found to meet the need.

Internal medicine

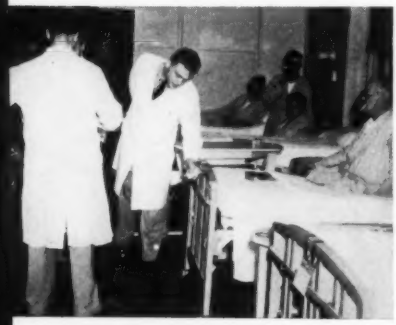
The Medical Department is organized with four permanent staff members: Dr. Charles G. Spicknall, chief of medicine, a deputy chief, and assistant chiefs for dermatology-syphilology and neuropsychiatry. In addition, consultants in internal medicine and subspecialties make regular visits to the hospital.

As in all residency programs within the U. S. Public Health Serv-



Radiology residents check over films.

Tumor conferences, on a regular schedule.



Residents on daily medical ward rounds.

ice, the columnar system is in effect. Re-appointments are made annually through the training period if performance has been satisfactory.

There are six residents in medicine, with two in each of the three years' training. The program provides graded responsibility and experience in the broad field of internal medicine plus neuropsychiatry, dermatology, syphilology and pediatrics.

The initial year is divided between outpatient and general medical ward work, under the supervision of a third year resident and the staff officers. In the second year, six months are spent in anatomic and clinical pathology, and six months on the general medical ward. This year also includes instruction in diagnostic radiological techniques in gastro-enterology.

The final year comprises six months in affiliation with the Johns Hopkins Hospital subspecialty clinics and six months either in general medicine or as senior medical resident. The latter assignment includes consultative work in other services, and opportunities in the medical aspects of surgery.

All medical residents participate in, or attend, regularly scheduled journal club and teaching conferences on neurology, radiology, hematology, endocrinology, cardiology and pulmonary diseases.

Osler Medical Rounds at Johns Hopkins Hospital are attended twice a month by each resident.

Surgery

The department is supervised by the Dr. Howard D. Fishburn, Chief, deputy chief, and assistant chiefs of the tumor service, orthopedics, urology, and anesthesiology.

There are six general surgery residencies approved for three years.

The initial six months are spent in general surgical work with emphasis on minor surgery and neurosurgery. The remainder of the year is divided between urology, general surgery and pathology.

The second year comprises six months in orthopedics and six months in the busy surgical outpatient department. During the latter assignment, anatomical studies are included.

The final year is divided equally between major general surgery assignments and the active tumor clinic. As a referral center for neoplastic diseases, the hospital affords excellent opportunities for training in this field.

Teaching conferences are frequently scheduled for the entire surgical resident staff. These include "slide" conferences weekly, joint meetings with medicine and radiology on chest diseases, case presentations and lectures on clinical and basic science fundamentals.

Radiology

This service is directed by Dr. Ira Lewis, chief, and a deputy chief.

There are four residents in this three-year training program. The

Hospitals and Residents

The majority of Public Health Service hospitals are general hospitals where all types of illness are studied and treated. They offer excellent opportunities for training of the younger officer and for teaching by the trained clinician. A close relationship between Service hospitals and medical schools provides opportunity for teaching and training at all levels and allows the clinical officer to work in a teaching atmosphere.

A few specialized hospitals are maintained for the diagnosis and treatment of tuberculosis, narcotic addiction, psychiatric disorders and leprosy, offering unique facilities for work and study in these fields. Any person in the country who has contracted leprosy or who is a narcotic drug addict is eligible for hospitalization at these special facilities. Persons in these categories make up approximately one-fourth of the patients in Public Health Service hospitals (exclusive of those provided for Indians).

Residency training in one or more PHS hospitals is approved in the following specialties—general surgery, internal medicine, orthopedic surgery, urology, anesthesiology, dermatology and syphilology, ophthalmology, pathology, radiology and psychiatry.

Seven of the United States Public Health Service hospitals are approved as teaching hospitals and offer residencies. Five of these offer internships. Interns receive pay equivalent to a Navy Lieutenant Junior Grade, and residents receive the same or more, depending on previous training and experience.

THE OFFICIAL SEAL of the Public Health Service bears the name of the organization and date of its origin, surrounding a fouled anchor crossed by the caduceus of Mercury. The fouled anchor signified a seaman in distress. The caduceus of Mercury symbolizes commerce and refers to the earliest function of the Service—the providing of medical care for sick and disabled seamen.

The Public Health Service was created when the Marine Hospital Service Act "for the relief of sick and disabled seamen" was signed on July 16, 1798. From that beginning, the history of the Service has been one of expansion and progress in the protection and improvement of health in the United States. From its origin as a hospital service in various seaports, later development in the fields of epidemiology and public health led to the establishment of the Commissioned Corps in January, 1889. Today all fields of medicine are represented.

first year's work is devoted to diagnostic roentgenology and fluoroscopy with formal lectures in physics and radiotherapy.

There is an active affiliation with Johns Hopkins Hospitals throughout the residency. The daily diagnostic sessions and physics lectures at that institution are open to the resident staff.

In the second year, formal classes in physics and therapy and film reading are continued. However, principal emphasis is placed on training in radiation treatment.

The third year is devoted to continued diagnostic experience, including a three month assignment to the Johns Hopkins Hospital in pediatric radiology.

The radiologic resident staff participates actively in the general professional conferences and inter-departmental clinics held in the hospital.

A radon emanation plant, under the supervision of the physicist, and radioisotope facilities, under his direction, are part of the therapy program.

Pathology

The department is under the direction of Dr. James A. Smith, chief. Residency is approved for four years and four positions exist. In the initial year, the resident performs the majority of the autopsies, reporting on the gross microscopic pathology. The hospital averages a postmortem rate of approximately 85%.

During this year, the resident also prepares material for staff presentations, supervises the intern, and rotates on blood donor clinic duty.

Major responsibility for surgical pathology, including the busy tumor service, rests on the second year resident. Material originates from various other Public Health Service facilities in addition to that from the Baltimore surgical service. This year also includes affiliative training in neuropathology with the University of Maryland School of Medicine.

In the third year, eleven weeks of postgraduate instruction is given in parasitology, bacteriology, virology, and myeology at the Communicable Disease Center, Atlanta, Georgia. Later, during six weeks' affiliation with Baltimore City Hospital, experience is gained in obstetrical, gynecological and pediatric pathology. Duties at the home hospital during the remainder of the year are chiefly related to bacteriology, serology, chemistry and hematology. One month at Johns Hopkins Hospital is spent in the latter subject.

In the final year, time is divided between clinical pathology and medicolegal pathology, including toxicology. In the latter field, an

Draft Status

Since active service in the Commissioned Corps is similar to that in the Army or Navy, such service satisfies the requirements of Selective Service. The 1955 Amendments to the "General Draft Act" provide that a person who has served for a period of 24 months or more as a Commissioned Officer in the Public Health Service will be exempt from further training and service, unless a declaration of war or national emergency is made by the Congress.

Active duty with the Public Health Service does not confer veteran status upon the officer unless he is assigned by the Service to the Coast Guard or to one of the other Armed Forces.

Grade Equivalents

PUBLIC HEALTH SERVICE	ARMY	NAVY
Assistant Surgeon	First Lieutenant	Lieutenant (j.g.)
Senior Assistant Surgeon	Captain	Lieutenant
Surgeon	Major	Lieutenant Commander
Senior Surgeon	Lieutenant Colonel	Commander
Medical Director	Colonel	Captain

eight weeks' assignment is made to the Medical Examiner's Laboratory in Baltimore. A two week period is spent at the Rh Typing Laboratory in the University of Maryland Medical School. There are also two one-week courses at the Armed Forces Institute of Pathology, one in Forensic Pathology and the other in Ophthalmic Pathology. In the last weeks, supervisory duties in the Pathology Department are carried.

Ophthalmology-Otolaryngology

Under the direction of Dr. Walter P. Griffey, the chief of E.E.N.T. Service, this training program, for three residents, is set up for a five year period. It is approved for three years in Ophthalmology. Additional training is afforded in otolaryngology, although approval has not yet been granted for this field.

The resident's activities are geared to graded responsibility as experience is gained. Scheduled instruction periods are held within the department and training is obtained through affiliation, some of which is at Johns Hopkins Hospital.

Commissioned corps

All residents in training at the hospital are commissioned officers in the U. S. Public Health Service.

The Public Health Service is the only commissioned service of the Government in which all officers are in the medical or scientific fields. Commissioned officers in the Public Health Service have the comparable pay and rank of the other uniformed services.

Mobile group

The wide scope of responsibilities discharged by Public Health Service officers requires that there be at

The Baltimore USPHS Hospital is one of sixteen "Marine Hospitals" in the U. S.

U. S. Public Health Service Hospitals

LOCATION	TYPE	BED CAPACITY
Baltimore, Md.	General, tumor service	400
Boston, Mass.	General, tuberculosis	275
Carville, La.	Leprosy	350
Chicago, Ill.	General	150
Detroit, Mich.	General, tuberculosis	200
Fort Worth, Tex.	Psychiatric, narcotic addiction	1,000
Galveston, Tex.	General	150
Lexington, Ky.	Psychiatric, narcotic addiction	1,340
Memphis, Tenn.	General, tuberculosis	135
Manhattan Beach, Brooklyn, N. Y.	Tuberculosis	350
New Orleans, La.	General, obstetrical, psychiatric, tuberculosis.	400
Norfolk, Va.	General	250
San Francisco, Calif.	General, tuberculosis	450
Savannah, Ga.	General, tuberculosis	150
Seattle, Wash.	General, tuberculosis	350
Staten Island, N. Y.	General, obstetrical, psychiatric, tuberculosis.	850

all times a mobile group of highly trained public health specialists—physicians, dentists, nurses, dietitions, pharmacists, sanitary engineers, etc., capable of meeting the Service's needs, both routine and extraordinary. Since the ever-expanding work of the Service necessitates more personnel than are authorized for the regular corps, provision has been made for the appointment of reserve officers.

Rank

The highest ranking officer of the Public Health Service is the Surgeon General, appointed by the President with the consent of the Senate. He holds the same rank as the Surgeon General of the Army, which is major general.

The Deputy Surgeon General also has the rank of major general. Assistant Surgeons General carry the rank of either brigadier general or major general.

The medical officers in charge of the hospitals are commissioned officers, usually with the grade of Medical Director. They are responsible for the full clinical and administrative operations of the hospitals.

Public Health Service grades and similar military ranks are indicated in the table (bottom of page 61).

Both regular and reserve corps of

Public Health Service officers may resign at any time that is mutually agreeable to the officer and to the Service, except in times of national emergency. Reserve officers, however, may be released from active duty at the discretion of the Service.

As commissioned officers of the Public Health Service, physicians in residency training receive the pay of the grade for which they individually qualify.

Residency training programs in Public Health Service hospitals are available to both regular and reserve corps officers. There is no so-called "obligated period of service" as a condition of appointment. However, the Service hopes to retain sufficient numbers of physicians completing these programs to satisfy its needs for trained medical specialists. Duty served in training status is not creditable toward fulfillment of the "Doctor Draft."

Applications for appointment to Public Health Service residency training must be filed with the Committee on Residencies and Internships by the previous November 1. Information concerning the Service-wide residency training program and application forms are obtainable from the Chairman, Committee on Residencies and Internships, Department of Health, Education, and Welfare, Public Health Service, Washington 25, D. C.

Woman Physician Fellowship

The Women's Medical Association of New York offers the Mary Putnam Jacobi Fellowship to a graduate woman physician, either American or foreign. This fellowship will start October 1, 1957 and will amount to $2000, $1000 being available October 1, 1957. The recipient of the fellowship will be expected to make a report to the committee at the end of the fourth month following which the second $1000 will be awarded subject to the approval of the committee. The fellowship is given for medical research, clinical investigation or postgraduate study in a special field of medicine.

Applications for this fellowship must be filed with the secretary of the committee by October 1, 1956 and will be acted upon by January 1, 1957. Application blanks may be obtained from the Secretary, Ada Chree Reid, M. D., 118 Riverside Drive, New York 24, New York.

Number seven of a series from leading medical centers

Clinico–Pathological Conference

U. S. Public Health Service Hospital, Baltimore, Md.

History

This 39-year-old colored male seaman entered a U. S. Public Health Service Hospital with a chief complaint of gradual painless swelling of his abdomen for a year's period of time. He had nocturia three or four times each night since the onset of the illness. On one occasion, eight months before hospital admission, he noted blood on his underclothing. There was no weight loss, dyspnea, dizziness, fainting spells or abdominal pain.

Eight years previously this patient was discharged from the Army after serving only eight months. The reason for discharge is not known to the patient. He thought he had malaria seven years ago. He had been married seven years; there were no children. He stated that he probably had syphilis some thirteen years ago.

Physical examination

On admission it was noted that the patient was a well developed colored male with a markedly protuberant abdomen. He appeared chronically ill but in no acute distress. He was well oriented, intelligent and cooperative. His blood pressure was 118/84; pulse rate was 84 per minute, and his weight was 129 pounds. His cheeks were sunken and his eyes were prominent. The trachea was in the midline. The lungs were clear to percussion and auscultation but a marked limitation of the diaphragmatic excursion bilaterally was noted. There was a soft systolic murmur in the pulmonic area and slight

THIS MONTH'S CONFERENCE was prepared by James A. Smith, M.D., Medical Director, USPHS Hospital, Baltimore, Md., Chief of Pathology, and Claude R. Garfield, M. D., Surgeon, USPHS Hospital, Baltimore, Md., Resident, Medical Service.

Announcing a New Potent Ataractic Drug For

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Drug For the Management of the Acutely Agitated Patient

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10-(γ-dimethylamino-n-propyl)-phenothiazine hydrochloride

- **The acute alcoholic**—delirium tremens, acute hallucinosis, tremulousness, inebriation
- **The acute psychotic**—acute excitation due to various psychoses
- **The drug addict**—withdrawal syndrome: nausea, vomiting, muscle and bone pains, abdominal cramps, general malaise

SPARINE is a new, clinically effective phenothiazine derivative. It has demonstrated impressive effectiveness in controlling acute excitation without inducing significant side-reactions.[1,2,3]

SPARINE may be administered intravenously, intramuscularly, or orally. The route and dosage are determined by the extent of central-nervous-system excitation and by the patient's response.

Supplied: Tablets, 25, 50, and 100 mg., bottles of 50 and 500; 200 mg., bottles of 500. Injection, 50 mg. per cc., vials of 2 and 10 cc.

1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia **25**:67 Feb. 1956. 3. Mitchell, E.H.: J.A.M.A. In press.

The **NEW** Phenothiazine Derivative

Promazine Hydrochloride

Philadelphia 1, Pa.

*Trademark

venous distention was noted in the neck.

The abdomen was markedly distended and a huge mass was percussible from the seventh rib on the left to the symphysis pubis; this mass extended across the midline. A definite notch was felt in the right border of the mass. No liver edge could be palpated. There was questionable shifting dullness. The superficial abdominal veins were visibly distended and filled from below. Shotty, firm, non-tender, freely movable cervical, axillary, epitrochlear and inguinal lymph nodes were palpated.

X-ray findings

A chest plate showed the right diaphragm to be elevated. Skeletal views of the arms, legs and skull were normal. A barium enema study showed a displaced colon due to extrinsic pressure. An upper gastrointestinal series revealed an extrinsic mass displacing the stomach medially. On an intravenous pyelogram, slight lateral and downward displacement, without rotation, of the left kidney was noted.

Laboratory studies

On urinalysis a specific gravity of 1.015, no albumin and an occasional granular cast was found. Blood Kahn was negative. Liver function tests revealed a one plus cephalin flocculation, negative thymol turbidity, and a serum bilirubin of 1.7 mg. per 100 ml. of blood. Blood chemistry studies showed a non-protein nitrogen of 32 mg. per 100 ml., a serum albumin of 3.5 gm. per 100 ml., and a serum globulin of 3.4 gm. per 100 ml. There were 1.7 King-Armstrong units on acid phosphatase testing.

On hematological studies, a sickle cell preparation showed no sickling. There were 2.6 million red blood cells and 10,000 white blood cells per cu. mm. There was 8.1 gm. of hemoglobin per 100 ml. Ten percent of red blood cells were reticulocytes. The hematocrit showed 23% packed red blood cells. There were 225,000 platelets per cu. mm. Blood indices were: mean corpuscular volume, 88 cubic microns; mean corpuscular hemoglobin concentration, 35 percent; and mean corpuscular hemoglobin, 31 micromicrograms. On differential count of the white blood cells there were 2% promyelocytes, 4% metamyelocytes, 25% band forms, 35% polymorphonuclear leukocytes, 1% eosinophils, 2% basophiles, 8% monocytes and 23% lymphocytes. There were 47 normoblasts per hundred white blood cells.

Sternal marrow

The first two attempts to obtain sternal marrow resulted in "dry taps." The third attempt was successful in obtaining bone marrow but the specimen was very small. The erythrocytogenesis was normoblastic with a myeloid-erythroid ratio of 1 to 1. The myeloid leukogenesis showed a preponderance of poly-

morphonuclear leukocytes. The megakaryocytes were reduced in number.

Thick malaria smears were negative for parasites.

Hospital course

One month after hospitalization a laparotomy was performed and biopsies of the liver, spleen and one lymph node were obtained. A bleeding tendency was noted following this operation, which persisted throughout the remainder of the patient's life. The patient was treated with supportive therapy. The clinical course was one of a slowly worsening of the patient's condition with expiration about 18 months from onset of the illness. The peripheral blood picture did not change appreciably from the time of admission. Death was somewhat sudden and unexpected. During the last days of the patient's life there was hemorrhage from the mucous membranes about the mouth.

Discussion and clinical diagnosis

This case presented is that of a 39-year-old colored male with progressive development of a tremendously enlarged spleen of at least eighteen months' duration and an insidious downhill course that was terminally associated with an abnormal bleeding tendency. Other significant physical signs were lymphadenopathy, probable hepatic enlargement as revealed in the high right diaphragm, and partial inferior vena cava obstruction due to the huge splenomegaly as revealed by the distended lower superficial abdominal veins that filled from below. Significant laboratory findings were a normocytic, normochromic anemia, normal white blood cell and platelet counts, myelocytes and normoblasts in the peripheral blood, reticulocytosis, elevated serum bilirubin, and a probable hypocellular marrow with an erythroid hyperplasia although a bone marrow biopsy was not done.

The most likely diagnosis is agnogenic myeloid metaplasia in view of the huge splenomegaly, lymphadenopathy, anemia, probable hypocellular marrow, and the normoblasts and early myeloid cells in the peripheral blood. This disease simulates chronic myelogenous leukemia by blood picture and indeed is considered by some to be a form of leukemia, and the diagnosis is made during life by finding evidence of active hematopoiesis in the spleen with the bone marrow not being characteristic of leukemia. There has been an occasional case reported of leukemia with terminal myelofibrosis. This patient may also have had an associated hemolytic anemia related to hypersplenism, which is not uncommon in this disorder and is important regarding therapy. The erythroid hyperplasia of the bone marrow, reticulocytosis, and elevated serum bilirubin suggests a hemolytic disorder and fecal urobilinogen or red blood cell survival studies would

have been helpful in this case.

Other diseases difficult to exclude entirely must also be included in the differential diagnosis — Banti's syndrome or thrombosis of the portal vein may be associated with tremendous splenomegaly and occasionally with normal liver function tests, but there was no evidence of esophageal varices, gastrointestinal hemorrhage, ascites, or hepatic coma. Schistosomiasis should be considered only as an etiological factor of cirrhosis with subsequent Banti's syndrome, and the diagnosis would have depended on finding the ova in the stool or liver.

A myelophthisis anemia or myelofibrosis with secondary myeloid metaplasia due to metastic carcinoma, Hodgkins disease, or other diseases should be considered, but would not be expected to result in such huge splenomegaly. Huge spleens weighing as much as 6000 grams have been reported in tuberculosis, sarcoidosis, leishmaniases, repeated bouts of malaria in the tropics and Hodgkins disease and may be associated with myelophthisis and hypersplenism, but these diseases do not appear to fit clinical history and course of this patient.

Congenital diseases to be considered are congenital hemolytic icterus and Gaucher's disease. Congenital hemolytic icterus, a Mendelian dominant type of heredity disorder related to intracellular erythrocyte dysfunction, shows a hypocellular marrow only during a pan marrow aplastic crisis. It results in a variable degree of hyperplastic splenomegaly, and is associated with a micro spherocytic type of anemia. Gaucher's disease, a rare familiar disorder of cerebroside or kerasin retention in the reticuloendothelial cells, has been reported in Negroes. It may have an insidious onset of hepatosplenomegaly with normal liver function tests and spleens weighing as much as 8000 grams. The disease may also be associated with secondary myelophthisis and hemolytic anemia. However, other associated findings usually noted in this disorder such as pinquecula, pigmentation of exposed skin and bone pain with skeletal changes on X-ray were not noted. The diagnosis is based on finding of the typical Gaucher cells in the bone marrow, liver, spleen, or lymph nodes.

Pathologic findings

Sections taken from a rib, the sternum and the body of the lumbar vertebra showed myelofibrosis. Scattered in the fibrous tissue were a few small islands of hemopoietic cells including megakaryocytes. The spleen weighed 6,290 gm. The sinusoids were packed by numerous hemopoietic cells and red blood cells. Lymph follicles were not present.

The liver weighed 5,150 gm. Its anterior edge was below the brim of the pelvis on the right. Because of the large size of the spleen and liver, the diaphragm was elevated somewhat extending from the fourth

rib on the right to the fourth rib on the left and the abdomen protruded. The lower pole of the spleen extended into the pelvis. There was an accessory spleen two centimeters in diameter which showed on microscopic examination the same architecture as the enlarged spleen. The sinusoids of the liver contained clumps of hemopoietic cells and numerous megakaryocytes. These groups of cells are thought to account for the tremendous increase in the size of both the spleen and the liver. No Leishman-Donovan bodies were found and no free fluid was noted in the abdominal cavity.

There was some enlargement of the preauricular, axillary, and abdominal lymph nodes especially those in the region of the pancreas, along the lessor curvature of the stomach and on both sides of the abdominal aorta. These nodes showed numerous hemopoietic cells encroaching on the areas usually occupied by the lymph follicles.

Clogging of capillaries and filling of sinusoids and of veins in many other organs were noted with these hemopoietic cells and megakaryocytes. Such was seen in the lungs, the testis, the pancreas, the adrenals, and in the smaller vessels of the brain.

There was a generalized oozing of blood from the mucosa of the gastrointestinal tract with 300 ml. of coffee ground material in the stomach, 500 ml. blood estimated to be in the lumen of the intestine. Blood crusts were seen about the mouth.

When cutting the brain it was noted that there was a total absence of the septum pellucidum with a fusing of both lateral ventricles into one cavity. Buried gyri were noted in the cortex of both parietal regions.

The body showed marked emaciation weighing an estimated 120 lbs. although being five feet ten inches in length. The subcutaneous fat of the abdomen was only about 1 mm. in thickness. Other findings were the pale color of the musculature on sectioning, apical adhesions of the right lung and parietal pleura and 150 ml. of clear straw colored fluid in the pericardial sac. A pterygium was noted on both the right and the left eyes. Some edema fluid was found in both lungs, the right weighing 565 gm. and the left 440 gm.

Clinico-pathologic correlation

It is thought death was due to anemia secondary to agnogenic myeloid metaplasia and to the generalized oozing of the mucosa of the gastrointestinal tract.

In agnogenic myeloid metaplasia, there is evidence that it is a proliferative disease of primitive mesenchymal tissue from which blood formation takes place in reticuloendothelial tissue (Vaughn, Harrison, et al)[4] as opposed to myelofibrosis with compensatory extra medullary hematopoiesis (Donhauser).[2] Recent

papers have shown that splenectomy is not contraindicated on the basis of taking a compensatory blood forming organ away from the patient in this disease and that the high mortality rate is related to such factors as poor condition of the patient, huge size of the spleen, and bleeding tendency.[3] While splenectomy has no effect whatsoever on the course of the disease, it may help the patient considerably by alleviating the hemolytic anemia or thrombocytopenia.

If a disease other than agnogenic myeloid metaplasia existed, possible specific therapy would have been indicated according to the primary process. Otherwise management of this type of case would be directed toward supportive therapy, such as antibiotics and transfusions as indicated, and toward a possible complication of hypersplenism as manifested by a hemolytic anemia or a thrombocytopenia bleeding disorder. If a hemolytic anemia or thrombocytopenic bleeding disorder exists, a trial of cortisone or ACTH therapy is in order. If such therapy fails and the bone marrow is not entirely aplastic, splenectomy should then be considered, irrespective of cause.[3, 5]

As to the absence of the septum pellucidum, thirteen other such cases unassociated with marked hydrocephalus have been described in the literature. Five of these were discovered at autopsy and eight by ventriculography. This condition has been described by Hochstetter[6] in the brains of fetuses therefore it is thought possible to be of congenital or intrauterine origin. The patient described in this paper was able to work and carry on a normal life with no obvious mental retardation or neurological handicap.

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I Quit Anesthesia

Arthur J. Prange Jr., M.D.

After more than a year's experience in anesthesiology, I decided to abandon the field to search for a specialty to which I felt more suited. Some of the reasons for this decision have a pertinence beyond what is merely personal and may be of interest to anyone considering a career in anesthesiology. It is these I intend to discuss.

Doctor's doctor

The anesthesiologist is truly the doctor's doctor. For the most part he serves patients through the agency of a surgeon, assisting him with *his* patients; only rarely does he act directly in a conventional doctor-patient relationship. The anesthesiologist is in the position of being not quite an independent professional man nor yet frankly a mere employee; and this ill-defined status carries implications which dog him throughout his professional life.

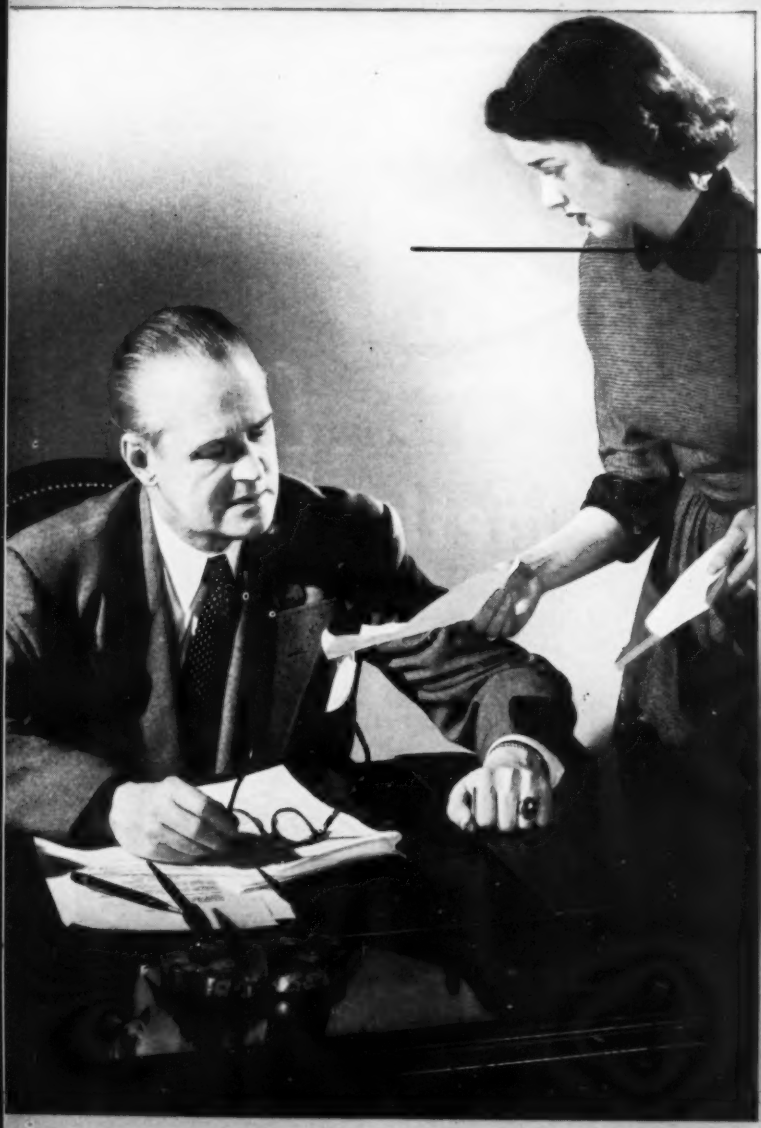
A similar situation obtains in other specialties, e.g. in pathology and in radiology. But nowhere in medicine is it seen in deeper relief than in anesthesiology.

The internist allows the pathologist a free hand in his laboratory determinations and leaves to the radiologist the prescription of the dose of roentgens; but the surgeon is unusual who does not harbor a nostrum or nurse an aversion in the field of anesthesia.

Whim or necessity

Unfortunately a surgeon's attachment or antipathy to this drug or that technique is generally more habitual than rational. In fairness, it must be

About The Author—Dr. Prange graduated from a Michigan medical school, had a rotating internship and one year of residency in anesthesia. Recalled by the Navy in 1952, Dr. Prange split eight months between two U. S. Navy bases, doing anesthesia. At his request he was transferred to a repair ship, serving as ship's doctor for the remaining two years of his Navy time. He is currently a second-year resident in psychiatry.



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1. Dripps, R.D.: Selective Utilization of Barbiturates, J.A.M.A. *139*:150 (Jan. 15) 1949.
2. Council on Pharmacy & Chemistry: New and Non-official Remedies, 1955, Philadelphia, J.B. Lippincott Co., 1955, p. 329.

said that this tendency is more prevalent among older surgeons and stems from times when they were in fact responsible for all facets of operating room procedure.

Be that as it may, the fact remains that the anesthesiologist must deal with surgical whims as well as with surgical necessities.

The problem becomes more complex when the patient, too, knows what *he* wants—usually oblivion via intravenous injection. It is often possible for the anesthesiologist to satisfy such a wish without jeopardy; perhaps to extend this pleasant circumstance, he goes to unusual lengths to gratify the patient's desires when an unpopular method would be more suitable. Deeper factors also determine this tendency to please. These will be discussed with the doctor-patient relationship.

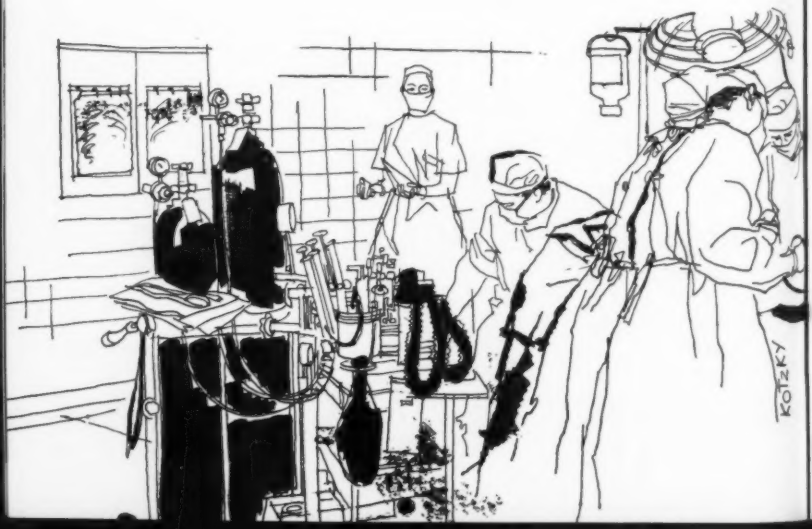
In any case, the anesthesiologist may find himself in the unhappy position of serving many masters and no one of them very well.

He cannot always insist on the rectitude of *his* course unless he is prepared to work in battle dress.

On the other hand, an attempt to satisfy all the contending parties, including himself, leads to the use of a hodge podge of drugs and techniques—a practice often decried but often followed.

If he simply placates the surgeon and the patient, the anesthesiologist must severely compromise his judgment. It is too easy for him to shrug his shoulders and say, "Maybe in this case 'pent' *is* as good as spinal." He loses his zeal for new knowledge if he has little chance to apply it.

The point is not that the anes-



thesiologist is *usually* involved in such a hassle. He isn't. The point is that his judgment is *ever* subject to such extraneous influences.

Captain surgeon

Nevertheless, the surgical team must have a captain, and the surgeon considers captaincy his function. The pure logic of his view may be tainted by mere tradition, for in countries that lack a heritage of non-medical anesthetists the captain is often the anesthesiologist. But, as the surgeon is wont to remind his colleague, "the patient comes to the operating room for an operation, not for an anesthetic." Like all other aphorisms, this one is subject to qualification. All the same, it is true. And the anesthesiologist must adjust his activities to it.

If I have exaggerated the aspect of strife, it is still necessary to point out that strife has a penchant for occurring when the issues at hand are most important. Conversely, when the various parties agree that "anything will do," often any of several methods *will* do.

Perhaps these remarks about the doctor-doctor relationship have only slight relevance to the situation in a teaching hospital. If the surgeon and the anesthesiologist are of equal official status, if the patients, in a sense, "belong" to the hospital, and especially if the departments of surgery and anesthesiology are separately organized, the controversial issues are subdued. However, in private practice, whatever the arrangements on paper, the anesthesiologist works *for* the surgeon, not *with* him. He is a sub-contractor whose livelihood depends upon contractors. Whether this is frankly stated or only tacitly understood depends to some extent upon the local supply and demand of anesthesiologists.

Patient relationship

The anesthesiologist's relationship to patients is as exceptional as his relationship to other doctors. He is not selected by the patient to be his doctor; he is foisted on the patient by the surgeon or the hospital. He is sent rather than called. This is usually not a source of discontent to the patient since he probably knows nothing of the anesthesiologists in his community. But the implications for the doctor are important. First, he does not have quite the command of the situation that selection by the patient would confer, and secondly, the doctor-patient relationship is likely to remain as impersonal as it began.

Anonymity

Ideally the anesthesiologist sees his patients before operation and a time or two afterward. Sometimes even these visits are delegated for the sake of expediency, and then he sees his patients only once, generally when they are unconscious.

It is true that over an extended period of time the anesthesiologist "treats" a large number of patients.

But these "treatments" are limited to a brief fraction of the illness and always the same fraction, viz. operation. For the most part the relationship is one of mutual anonymity. The anesthesiologist knows his patients' physiologies but not their personalities, and he often finds himself "doing a stomach" in the morning and a "gall bladder" in the afternoon with little knowledge of the persons of whom these organs are a part. To some doctors this impoverishment of the doctor-patient relationship is of no concern; to others it represents a loss of a large share of medicine's rewards.

The above remarks might be called the sociology of the field. Now mention must be made of the practice.

Suddenly, a crisis . . .

In the absence of an emergency the daily practice of anesthesiology is apt to be dull, no matter how fascinating one may find the subject matter of its parent sciences. For hours, even days, all goes well. Then suddenly there is a crisis. The time for recognition, diagnosis, and treatment is measured in seconds. The anesthesiologist, who has been the observer of events, must instantly become the instigator of life and death decisions. To be prepared to spring from quiescence to full activity he must constantly parry the temptation to be lulled into a false sense of security. All doctors make crucial decisions, but only the anesthesiologist makes them routinely under emergency conditions.

Most of the work is detailed and much of it requires a high degree of manual dexterity. More than other

specialties, anesthesiology emphasizes the science of medicine to the relative depreciation of its art; and among the tributary sciences the "pure" are nearly as important as the applied—physics as physiology, chemistry as pharmacology. These considerations, coupled with the poverty of the doctor-patient relationship, make it imperative for the anesthesiologist to view medicine, or at least his part of it, more as a branch of the physical sciences than of the humanities.

Familiar methods

By attacking disease, medicine attempts, with indifferent success, to eliminate its reason for existence. By improving its pharmacopeia anesthesiology has actually succeeded in obviating the use of some

of its methods most interesting to the anesthesiologist. Take the brachial block. This is a procedure which, in practiced hands, is admirably suited to certain types of cases. If the only alternative were, say, open drop ether, it would often be used. But in point of fact, newer techniques and drugs are so safe, so rapid, and so satisfactory, that brachial block, like many other conduction techniques, has fallen into virtual disuse. On rare occasions they may still be specifically indicated. But then one has had so little experience with them that he falls back on more familiar methods.

Choice of anesthetic

In training programs there may be special provision for teaching con-

duction anesthesia, but in practice, where the patient's desires and the surgeon's demands are of greater weight and where time is of the essence, there is scant opportunity to use them. The practice is open to criticism, but it is illustrative of the point that a few of the newer drugs are so generally applicable that some anesthesiologists use these same few in nearly all their cases.

Progress deserves applause. But the viewpoint of this article is not disinterested, and the paradox must be shown: as the anesthesiologist's choice of techniques and drugs expands, the variety he chooses contracts.

Contributions limited

There is another limiting factor. Anesthesiology is the only specialty that serves one other, viz. surgery, to the practical exclusion of the remainder. So long as this is true, the horizons of anesthesiology can hardly extend beyond the horizons of surgery, and if we examine the latter carefully, we find that there remains neither cavity nor organ where the modern surgeons fear to tread. That surgeons dare enter the chest, for instance, is very significantly the result of progress in anesthesia but this type of contribution —the conquest of new areas—is the greatest that anesthesia can hope to make. Such contributions are severely limited by human anatomy; the variety of organs is finite.

Surgical problems remain, of course, but for the most part they are not problems of opening virgin territory; they are problems of deciding what best to do in territory already explored. In the first instance the anesthesiologist was of inestimable importance, but in the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1January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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present case he must be content to play a lesser role.

It would be absurd to suggest that there remains no room for continued improvement in anesthesiology itself. Techniques, for example, will be refined and further adapted to the very young and very old. However, it is noteworthy that anesthetic risk nowadays is only rarely the factor prohibiting operation. Very few patients cannot "take" a modern anesthetic. Future progress will be in the gray realm of statistics and not in startling innovations.

Satisfaction in anesthesiology

Then what are the sources of satisfaction in anesthesiology, beyond good income and tolerable hours? I have mentioned limited goals, restricted future, and an attenuated doctor-patient relationship. Within this abbreviated framework it follows that rewards must be correspondingly diminished. The anesthesiologist must live on the thin soup of knowing that he has performed his part of total patient care as well as current understanding permits. Most doctors want — and get — more than this from medicine. It would be difficult to find a specialty in which patients always love their doctor. But in anesthesiology, they rarely even know him.

All this is not to paint a necessarily dark picture of anesthesiology but rather to portray it as being singular in the gallery of medical specialties. Because of anesthesiology's special requirements of th anesthetist, certain traits of chara ter would be of the greatest help t the anesthesiologist.

Mechanics and hegemony

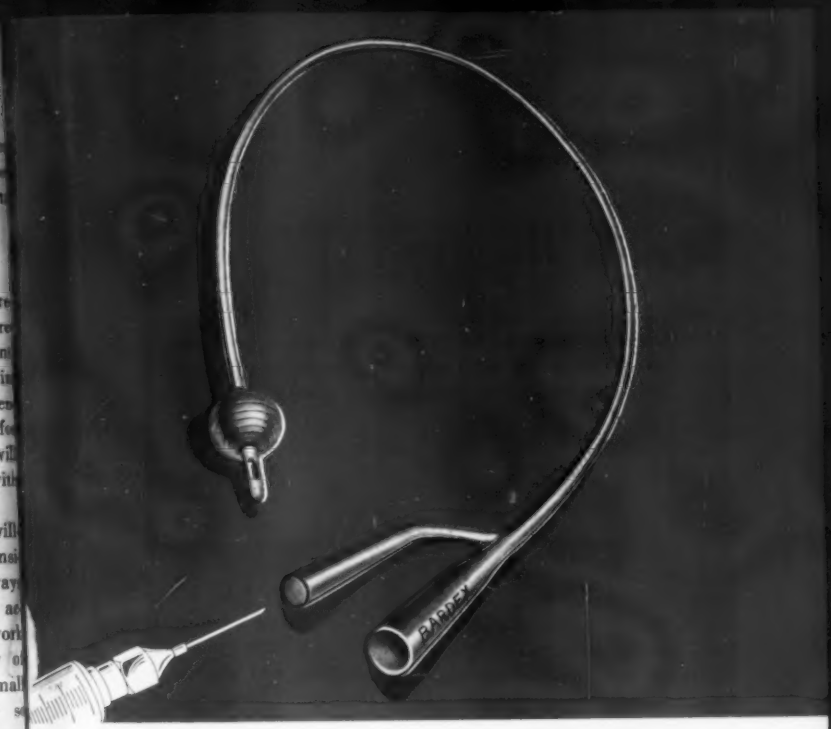
He must be content with near bore dom as his usual lot and yet be pre pared for high drama at any instan

He is happier if he is more in trigued by the mechanics of his en deavors than in the patients fo whom they exist, for his patients wi usually be senseless when he is wit them.

The anesthesiologist must be will ing to accept enormous respons bility although he may not alway have the authority that should ac company it. He must be able to wor gracefully under the hegemony o another doctor, yielding in smal matters to maintain harmony s that he may stand fast on greate issues to promote safety. The need for compromise implies the need fo uncommon judgment. He must com prehend the abstractions of severa sciences while possessing the dex terity of a good mechanic.

Few men indeed possess all thes desiderata, but some do come close And perhaps from them may com the dissent with which to represen the opposite face of the coin. Thi is to be desired; certainly there i much to be said for a career in anesthesiology.

But the points they will rais seemed inapplicable to me. So quit.



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Moving is YOUR Business

If you're making plans to shift your household from one state to another, here are some facts you should know to save you time, trouble and money.

John H. Gabriel

Many residents will be on the move in July. Some will be leaving their present hospitals, perhaps moving on to another hospital for more training. Others will be heading cross-country to begin practice. Of course, some will merely be taking off for a few weeks of vacation; their big move may be a year or more away.

But whether you are moving now, next month or next year, you would be wise to give some study to the situation beforehand.

Moving is almost never fun. The mechanics involved in arranging, packing and worrying your household goods many miles across country is a big job. It can be less of a job if you know what movers do and don't do, what they can and can't do, and what they charge for their services.

ICC regulated

Interstate moving of household goods is regulated by the federal government through the Interstate Commerce Commission (Motor Carriers Act of 1935). And under the ICC's watchful eye, interstate carriers must publish their rates and rules. These are called *tariffs* in the moving trade.

About the Author—An executive with one of the large nationwide movers, Mr. Gabriel is also the author of several publications directed toward improving the performance of the moving industry. Connected with transportation and shipping for more than 25 years, he has specialized in the domestic moving business for the past ten years.

One of the ICC's requirements says that tariffs must be accessible to the public in the offices of the mover and his appointed agents. This is important. The tariff will provide you, the shipper, with some pretty dull reading—chuck full of very valuable information; particularly concerning the terms of your contract with the mover.

Contract terms

Although the contract provisions are shown on the reverse of the mover's *bill of lading* (as well as in his tariff), they are seldom printed on the carrier's *written estimate* (or *Order for Service*)—which in most cases will be the first written document you will receive from the mover.

Shipping and delivery dates

Here's an excerpt from a mover's tariff:

"No carrier is bound to transport said property by any particular schedule, vehicle, train or vessel or otherwise than with reasonable dispatch."

What does this mean to you? Simply and importantly this: Your goods are handled and transported *without guarantee of shipping and delivery dates.* There is one exception: In *expedited service,* a shipment of *less than 5,000* pounds may be delivered on or before a specified date provided that you pay the mover on the basis of 5,000 pounds.

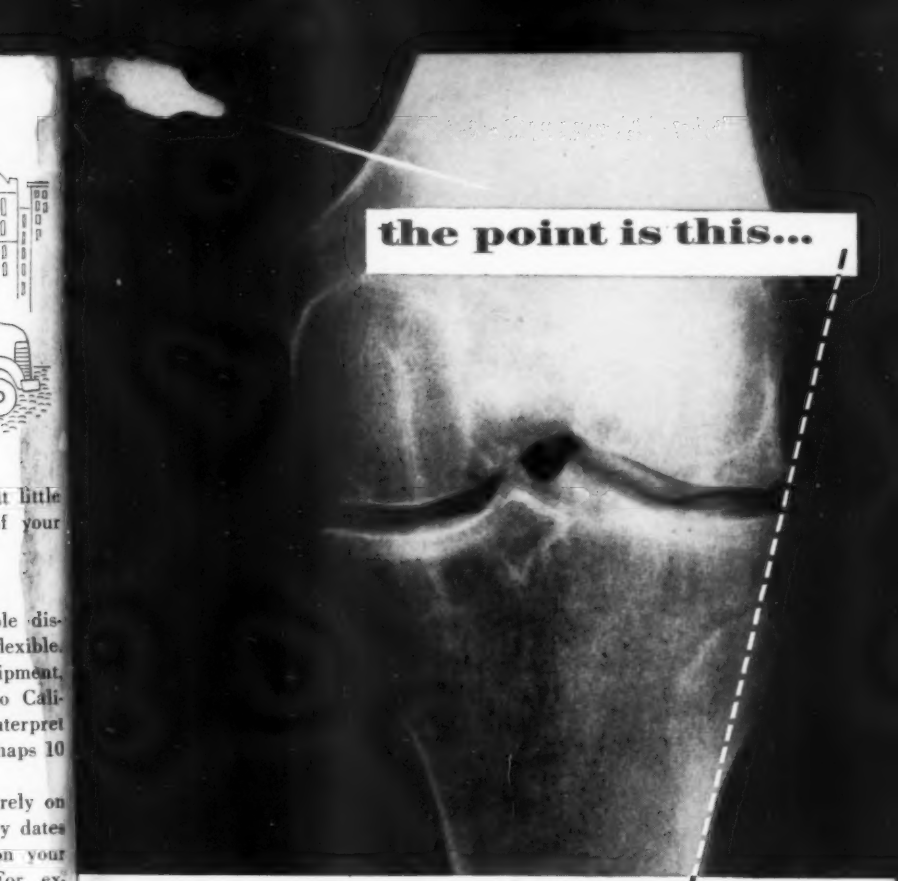
Thus, outside of this exception, you'll get no guarantee as to shipping and delivery dates. That little item could foul up a lot of your plans.

Reasonable dispatch

The phrase: "with reasonable dispatch" is, of course, very flexible. Applied to an average shipment, let's say, from New York to California, one mover may interpret "reasonable dispatch" as perhaps 10 days, another by 20 days.

The fact that you cannot rely on definite shipping and delivery dates has an important bearing on your calculation of expenses. For example, while waiting for arrival of your goods you may run up some daily expenses in the form of hotel or motel bills, outside meals, and a wide assortment of incidentals. The mover, of course, assumes no liability for these extra living expenses.

Suggestion: Choose a mover who, according to the volume of traffic carried by him and the frequency of more or less regular trips, can



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provide you with some assurance of prompt transit and delivery.

Physical necessity

Here's another quote from the tariff:

"Every carrier shall have the right, in case of physical necessity, to forward said property by any carrier or route between the point of shipment and the point of destination."

Of course, the ideal in handling your goods is by direct loading of the shipment (at your residence) on the overland van and direct delivery by the same van to ultimate destination, your new home. Every transfer "over a warehouse" involves stacking up your goods and every transfer from van to van is a potential source of damages, mis-deliveries or shortages. It certainly won't improve the condition of your goods to be handled unnecessarily.

This problem can be one of your bargaining points prior to closing a contract. Insist on the best possible handling of your shipment. Your overall objective should be for *one direct move without any transfer from origin to destination.*

Suggestion: It may be better to wait a few days for a through van, rather than have your goods go first to a warehouse where they will be stored until a van is available. Extra handling is best avoided.

Split shipment

One of the premises for the economical operation of a moving van is, of course, the full use of its loading space. In most instances the load a single shipper will not fill a va The mover must consolidate several loads on one van. Perhaps the van assigned to your goods may already be half or three-fourths full when arriving in front of your residence. With foresight and close calculation on the part of the estimator (salesman) plus the loading skill of the driver, your entire load may fit perfectly (without putting any part of your shipment on the tailgate).

But, the mover should not attempt to "squeeze" your load into his van and on the tailgate. Nor should h break up your load, putting part the shipment on the van presently ready for loading, and the balan on a second van which may be available perhaps days or even a week later. Splitting your shipment, loading it in two parts, means only inconvenience, if not hardship, for you the customer. *It cannot be done without your consent.*

It is one of your bargaining rights to insist that your entire shipment be loaded on one van.

Preparation

Will you take everything? First you'll want to know (more or less reliably) how much it will cost you to have your goods carried to y destination, including the cost adequate packing and insurance When you have that approximate figure you can decide whether you

want to take all of your possessions with you or perhaps dispose of some of the older or more bulky items prior to the move.

Every cooperative salesman in the moving industry will gladly advise you as to the approximate weight and proportionate cost of transportation for a certain given item. You can then decide whether you wish to include it in your move or not.

You may consider disposing of items which, by their nature, are difficult to transport.

Negotiation

Now, you start negotiating with movers. It's advisable to approach several moving firms.

Suggestion: Don't accept estimates for long distance moving over the phone. Make it a point to invite estimators of at least three moving concerns to your house or apartment for an on-the-spot check.

To expedite negotiations, have a list ready for them. List all pieces of furniture, mechanical appliances and other items of bulk or value. See that he leaves a copy with you. Movers have printed forms for this purpose. This may seem a minor point but it effectively eliminates any later dispute over items inspected by the salesman.

Estimates

After the representatives of at least three movers have visited your home, you will be left with three written estimates from which to choose.

Though you've shown each salesman the same articles, their estimates, based on weight, will often vary. This can be due to an honest difference in opinion or judgment. But you may find an occasional operator of questionable business methods who will deliberately give you a lower weight estimate in order to get your business.

Let's stop here for a minute. All

estimates, carefully established though they may be, are still only educated guesses.

You, the shipper, must pay for the *actual net weight* of your shipment as established on a certified scale or by a certified weighmaster. The total weight thus established is multiplied by the tariff rate of the mover. In this way you arrive at your cost.

Check estimates carefully

Keep these points in mind:

1. No agreement on a so-called flat (or lump sum) rate is permissible under the law.

2. The mover's estimate should always specify *accessorial charges* such as packing (this again to be specified: so and so many barrels, boxes, cartons, crates etc., at the individual rate of mover's tariff), insurance, storage in transit, and any other pertinent additional charges outside the actual *cost of freight*.

3. The mover may make a mistake in his calculation. He might omit a legitimate charge in his estimate. When such a mistake is uncovered later, the mover will try to correct it and to collect the respective difference from you. *He is held by ICC regulations to charge correctly and in accordance with his tariff.*

Suggestion: Check all estimates. Compare them. Try to clear up with the mover in whose services you are most interested, any discrepancy which you may note. Do this *prior to closing the contract.*

If all are fair and honest estimates, the difference won't be large. A reliable estimator can hit your load weight within 5% to 10% under or over the actual net weight (to be established on the certified scale). If one estimate is out of line, find out why.

Shipment weight

What you actually pay for is the net weight of your goods as determined by a certified scale and at the applicable rate of mover's tariff. Regulations of the Interstate Commerce Commission require each carrier shall determine the tare (empty) weight of each vehicle used in the transportation of household goods by having it weighed *prior to transportation of each shipment*, without the crew, by a certified weighmaster or on a certified scale. When weighed, the gasoline tank is full and the truck contains all blankets, dollies, hand trucks, pads, chains and other equipment needed in transportation of your shipment.

After the van has been loaded, it is again weighed. The net weight (that's what you pay for) is then determined by deducting the tare weight from the loaded weight.

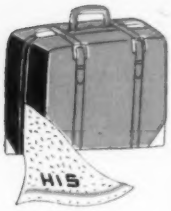
Where no adequate scale is located within a radius of 10 miles of origin, a constructive weight (based on 7 pounds per cubic foot of properly loaded van space) is used.

The gross weight, tare weight and net weight (or the constructive weight) shall be shown on the freight bill.

You, the shipper, have a right to know that the weighing procedure is carried out correctly and in accordance with these regulations. Any involuntary mistake will result in your having to pay for a higher weight on the basis of a 100 pound (higher) freight rate. (Imagine two husky men, at about 200 pounds each, accidently stepping on the scale at weighing time.)

For the asking

Another ICC rule: "After the ship-



ment has been weighed, the carrier, *if requested by the shipper,* shall immediately notify the shipper of the weight thereof and the charges, by telephone or telegraph. The notice *shall be at the carrier's expense,* unless the carrier provides in its tariff that the actual cost of such notice shall be collected from the shipper."

This is important because you want to know the weight of your shipment and the amount you have to pay for your move as early as possible, certainly before you leave.

You can also get a re-weighing if you have any reason to doubt the reported weight.

Loading of tailgates

Occasionally a metal bed frame, a step ladder, or a second hand bicycle are loaded on the van's tailgate. This sort of transportation should not be extended to valuable pieces of furniture, upholstered furniture, mattresses, barrels or drums filled with breakable china, glassware, cartons filled with linen, drapes, cushions or books, or in short, to any article of value.

Transportation on a tailgate is a potential source of damage due to a) stronger vibration en route, b) occasional rope burns caused by the ropes holding the load on the tailgate, c) occasional water damages by rain.

If you can agree with the mover in writing that he will not make a tailgate load with any of your goods, so much the better. Use this as one of your bargaining rights prior to closing a contract with a mover.

Knocked-down articles

For reasons of van space economy a driver will take apart certain pieces of furniture or appliances. Such items must be put back into their original condition by the mover. If by this "knocking down" procedure the mechanism is damaged or certain fixtures (bolts etc.) are lost, you have a legitimate claim against the mover.

Containers

Suggestion: Make it a condition of your contract with the mover that all articles which are suitable for packaging in

packing containers will be packed in your residence.

Wardrobes for wearing apparel may be rented from the mover. As soon as your wardrobes have been packed, have the driver seal the edges with scotch tape (movers have such tape, very often with the name of the firm imprinted on it). If you so desire, you may write your name in your handwriting over these seals. Cartons for the packing of lamp shades, linen, other soft goods, books etc. should be sturdy, clean, not damaged or gouged and close easily.

Mover's tariffs provide for various rates for small, medium and large cartons. Be sure you are charged the proper rates. For details, study mover's tariff.

Suggestion: Have an understanding with the mover, prior to closing the contract, that all cartons will be properly closed, tied with twine and sealed after packing. Have the mover or his driver seal all the cartons with scotch tape.

To protect mattresses and box springs from becoming torn or soiled it may be advisable to order special mattress cartons from the mover.

Special packing

Small radios may be packed into drums or cartons. Small pictures, paintings and mirrors may be packed into drums and/or cartons. Portable typewriters in their own durable cases may travel unpacked, but properly padded.

Where to pack what

ITEM	HOW PACKED
Wearing apparel.	**In wardrobes.**
China, glassware, crockery, pots and pans.	**In barrels, fibre drums or specially constructed cartons of great durability.**
Lamp shades, linen, other soft goods, books, files, albums, small pictures, small paintings, mirrors, radios.	**In cartons of various sizes; also in boxes.**
Larger mirrors, paintings and plate glass.	**In crates.**
Mattresses and box springs.	**In special cartons or bags of paper or plastic. (Your option.)**

Do not allow any of those uncountable, small items to leave your residence without proper packing. Naturally, there are smaller items such as children's toys (tricycles, wagons, etc.) which can travel without packing though they should be padded in furniture pads.

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Lamp shades should first be wrapped in tissue paper and then in a stronger outside paper or some clean fabric. Do not pack in newspaper; the print may rub off on the lampshade. Lamp shades are safe in drawers or packed in durable cartons.

Lock footlockers, trunks and suitcases securely and take the keys with you.

Insist that your rugs and rug pads are rolled. *They should never be folded.* Folding causes creases, often difficult and expensive to remove.

Regular hours

It is understandable that the mover wants to get his work done quickly and have his equipment rolling (especially during a busy season). On the other hand it is your right to demand that the work of packing, loading and unloading be done properly and not in such haste as to damage any part of your property.

You may request that all work, both at the time of loading and at the time of delivery, be done during regular working hours and not at night, on a Sunday afternoon, or on official holidays. Suppose the mover arrives with your load at your new residence at 4 or 5 P.M. and wants you to receive your goods that same evening. This is an unreasonable demand. You can and should tell him to come back the next day.

Unloading a shipment, setting up furniture and unpacking containers may take 3 to 5 hours. You may have no light in your new premises. It is extremely hazardous for you, the driver and his helpers to unload at night. The hours of work stated in the mover's tariff are worth reading. *See the tariff of the mover whose services you are going to use.*

Before the move

1) Have your utilities disconnected.
2) Have your TV aerial removed from the roof of the house. Your aerial will be "knocked down" to

several pieces. Have them packed in a bundle and have the mover attach a tag for proper identification.

3) Have your mechanical appliances properly serviced for safe transportation. *Carrier does not assume any liability unless these appliances have been properly serviced.* This refers in particular to automatic washing machines, refrigerators, deep freezers and television sets.

4) Radio phonographs — remove needle or, if it is of the permanent type, wrap it in cotton and tie it in place. *Fasten playing arm to the supporting rest or post.* Fill turntable compartment with padded newspaper to prevent movement of the turntable and the arm, provided it is not fastened to a supporting post.

5) Report change of address to your post office, publishers.

Food

Dispose of all perishable food prior to shipment. Breakage of bottles and glasses with liquid or semi-liquid contents has caused considerable damage to upholstered furniture or other items while in transit.

Legal liability

Most general movers operate on a limited legal liability called the declared or released valuation. Shippers usually choose the lowest bracket of this released valuation (30 cents per pound per article) because under this they enjoy the lowest freight rates.

Aids to Moving

A 35-page mimeographed booklet on cross-country moving is available for $1 from the author of this article. Address him at P.O. Box 67, Clayton, Mo.

A pamphlet, "Moving to Another State?" is available free from from the Movers' Conference of America, Sixteenth and P Sts., N. W., Washington 6, D. C.

The meaning of this system of released valuation is that the carrier, in the event of damage or loss, will not be liable for more than 30 cents per pound per article. He will not pay you higher than this rate. If your loss or damage claim is lower than 30 cents per pound, he will only pay you for the smaller amount.

Limited carrier's legal liability is often regarded by the public as a basic insurance. It is not. If you have a specific article as, for example, a high-priced original painting, you may declare its valuation in excess of the released valuation. This is done in a special column of carrier's Bill of Lading. In accepting this particular item for safe transportation, the mover will charge you a special fee of 2% of the total excess value declared.

Extraordinary value

Movers will not accept any liability for certain property of "extraordi-

nary value." Among these are: bankbills, coins or currency, deeds, notes, drafts or valuable papers of any kind, jewelry, postage stamps, stamp collections, revenue stamps, letters or packets of letters, precious stones, or articles of peculiarly inherent or extraordinary value, precious metals or articles manufactured therefrom, passports, birth and wedding certificates, or papers concerning your hospital or military record. Take these items with you on your trip. Don't ship them.

Insurance

It is evident that carrier's legal liability under released valuation of 30 cents per pound per article will not sufficiently protect you from damages or losses which may occur while your goods are in transit, or in the custody of the mover, his assistant or agents.

A wise shipper will insure the risk (either directly or through the mover) with a reputable insurance company.

Trip transit insurance is a broad sort of coverage which insures "against risks of physical loss or damage from any external cause." However, it is not an "all risk" insurance, because it excludes certain items from the insurance altogether and excludes some specific risks. Ask your mover for the details of the insurance plan and ask to see a specimen of the policy or certif

". . . and carrying heavy objects frequently results in *acute strangulated hernia* which can be. . ."

cate issued by the insurance company.

One of the main requirements for a really effective insurance is coverage for an amount which represents the present-day, realistic value of your shipment.

If you do insure for a lower amount, the insurance company will apply the co-insurance clause and penalty. This clause assumes you are a co-insurer of the *difference between the real value of your goods and the amount insured for.* As a result, in case of damage or loss, the insurance company will pay only a proportionate share.

The premium for a complete insurance is generally 50 cents for each $100 declared.

Some movers may require the insurance premium to be paid prior to shipment, that is, at the time when the insurance policy or certificate is presented to you. When you order insurance through the mover you are entitled to receive the policy or certificate prior to shipment. In fact, this is one of the Interstate Commerce Commission regulations.

If you already have a Personal Floater Policy, it may also be applied to your move and you need not take out an additional trip transit insurance. However, most Personal Floater Policies exclude certain risks as, for example, the risk of breakage of fragile articles such as ordinary china and glassware. Discuss this with your insurance broker.

Lump sum valuation

In lieu of trip transit insurance, a protection method for shipper's goods has recently been offered by a group of movers. If you choose to declare in writing a valuation higher than 30 cents per pound, the mover may carry this risk under the name of *lump sum valuation.* He will charge you a valuation charge of 50 cents for each $100 value declared. This charge is identical to the insurance premium which you would pay through the mover to an insurance company.

Inventory

The mover's inventory is supposed to enumerate all the goods loaded out of your home, and the copy which you will receive from the driver after loading represents the mover's receipt to you. However, it is not the practice of the moving industry to enumerate each item packed in drums, cartons, wardrobes, etc.

The inventory should show each *separate* item not packed in a container and each container which leaves your house.

Check the inventory carefully at the time of loading and unloading.

Exceptions

In a special column on your inventory is a place for the condition of each item at the time of loading. You will do well to check the condition remarks of the driver very carefully.

If you don't agree with the driver on any item, straighten this out before the item is taken out of the house. Better still, ask the driver to show you, prior to loading, any *exception* (condition remark) on any given piece so that both of you can agree on the *exception* to be inserted in his inventory. This is necessary in order to avoid any later discrepancies with the mover.

Inventory Abbreviations

ABBREVIATION	MEANING
B.O.	Bad Order
V.B.O.	Very Bad Order
P.B.O.	Packed By Owner
P.B.C.	Packed By Company
M & S	Marks and Scratches
S.C.	Scratched and Chipped
G or GO	Gouged
R	Rubbed
M E	Moth Eaten
X	Soiled
W	Worn
B or BR	Broken
C.U.	Condition Unknown
L	Loose
T	Torn

This list is not complete; also, some movers may use slightly different abbreviations. In case of doubt request an explanation from the driver.

Checking in

Checking in at the time of delivery is important; take your time with it. Sign driver's inventory only after you have made sure that you have received all your goods in accord ance with his original inventory an your copy.

If you find any damages or shor ages, this is the time to discuss the with the driver. At this time, li all *your* remarks. It is advisable t have the driver countersign thes exceptions. This is of importanc in any later claim against the move

Loss and damage claims

If your are reasonable, you'll realiz that on a long distance move cros country minor scratches and mar can occur even though the greate care may have been used in paddin your goods at the time of loading Such mars and scratches can ofte be eliminated by a good furnitur polish. They should not necessaril be the subject of claim towards th mover.

However, in any case of seriou damage or loss, you should file you claim against the mover immediately If your shipment was insured, fil your claim directly with the insur ance company, or send them a cop of your claim notification addresse to the carrier.

A responsible mover will do every thing in his power to bring a legiti mate claim to a prompt and satis factory settlement. The proper in vestigation of a claim, however, ma take the mover some time.

If a claim is delayed beyond th normal time of processing, your com plaint to the regional office of th Interstate Commerce Commissio

and your local Better Business Bureau may result in the necessary speeding up of the claim settlement. (However, in this connection neither the ICC or Better Business Bureau has any jurisdiction over the adjudication of such claims. They will refer you to a court of competent jurisdiction). In case of delayed settlement where your shipment was insured under trip transit insurance, contact the insurance company directly.

Regardless of the delay, you cannot hold back payment of any charges due the carrier. This is a popular misconception. The carrier is not even obligated to entertain your claim until all his charges have been paid.

Payment of charges

An excerpt from tariffs of the movers reads: "The carrier will not deliver or relinquish possession of any property transported by it until all tariff rates and charges thereon have been paid in cash, money order, or certified check. . . . "

The emphasis is on *payment in cash, money order, or certified check prior to delivery.*

Government personnel

Shipments of household goods for military personnel represent a large percentage of the entire volume of moves all over the country. This traffic is controlled by expertly staffed transportation offices attached to the various branches of the service. Government bureaus dealing with the direction of this traffic have informative printed guides for Armed Forces personnel on this subject.

How much?

To get a rough idea of what it will cost to have your gear hauled to wherever you're going:

1. Estimate the total weight of everything you're taking along. Do the big pieces first. Then bulk items such as clothes, linens, books under separate headings and guesstimate their weights.

2. Figure out the number of miles involved in your move.

3. Using both these figures find your estimated cost figure in the table below.

4. To this cost, add:

- **a) $15 for each thousand pounds (accessorial charges).**
- **b) 3% Federal tax (include accessorial charges when figuring tax).**
- **c) $5 for each $1,000 value (insurance).**

APPROXIMATE MOVING RATES

	number of pounds				
miles	1,000	2,000	3,000	4,000	5,000
100	$ 40	$ 60	$ 90	$100	$130
200	60	80	120	130	170
300	75	100	150	160	200
400	85	115	175	185	235
500	90	130	195	210	265
1,000	135	195	290	325	400
2,000	210	300	440	540	675
3,000	250	345	520	650	800

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Equipping the Urologist's Office

In furnishing offices for the practice of urology, two points should receive major consideration at the outset. First, the urology practice deals for the most part with adult patients, the majority being elderly. The second factor concerns a frequent complaint of the urology patient: incontinence. The latter, of course, indicates that the urologist's lavatory should be accessible from the waiting room.

Waiting room

Since the elderly adult is apt to be considerably less agile than, say persons in their thirties, care should be taken that the waiting room is as accident-proof as possible. For example, though surveys of specialists other than urologist's were in favor of easy-to-maintain tile flooring in the waiting room, urologists were not in agreement.

Floor covering

The majority of urologists questioned in the survey indicated that tile floors were more slippery; consequently the less agile patient was more likely to lose his footing. Most reported that they had covered their waiting room floors with some form of cloth carpeting.

The cost of broadloom or mixed wool and viscose carpeting runs between $7 to $12 a square yard, including underpad. A waiting room measuring 12 by 15 feet would require between $150 to $250 for carpeting, depending on the quality of the carpet and also whether wall to wall carpeting was used. (Most urologists responding did not cover their entire floor dimension with carpet.)

Furniture

The basic item of furniture in the waiting room is the chair. Urologists generally allowed for the fact that their patients would often be accompanied by a friend or relative at each visit. Thus, a couch and three other chairs would accommodate perhaps three or four patients. (This, incidentally, was the average accommodation reported by practic-

ing urologists; most were careful in scheduling appointments.)

The type of chair used in the waiting room depends upon various factors. Plastic or leather-covered, and upholstered or foam rubber are equally comfortable. However, as with other specialties, many urologists expressed a preference for the plastic-type chair because of its durability and the ease with which it can be kept clean; a cloth dampened in water is all that is required to care for this type of furniture. There is little to choose between types as far as cost is concerned. Any good chair will cost from $30 up to $80. Average price per chair reported by those surveyed was $40.

Necessary items

Other pieces of waiting room furniture required by urologists included lamps, tables for magazines, wall decorations, ashtrays and, if desired, some type of indoor plants. Here again, the urologist will be guided by the ages of the majority of his patients.

Table lamps were preferred, each equipped with no less than a 100 watt bulb and carefully shaded to throw light down on the lap of the patient who wishes to read. Ashtrays should be plentiful. To prevent the possibility of damage to furnishings caused by spilled ashes or a burning cigarette, buy only the big, bowl-type ash trays; they can be attractive and functional without being dainty. More than half of the urologists reporting had at least one ashtray and stand which could be moved.

Tables should be sturdy and provide a large expanse of surface to accommodate a sufficient number of magazines and ashtrays. Cost need

What equipment is needed by the urologist who is completing his residency and preparing to open an office?

RESIDENT PHYSICIAN recently put this question before a number of practicing urologists. Cautioned to keep in mind that cost was an important factor for the new man starting out, many responding specialists described some of the costly mistakes they had made when equipping their own offices.

Based on their experiences, this article is presented as a general guide for those residents who will soon be equipping their own offices for the practice of urology.

Though such things as decor, style and layout of an office are best decided by each physician (or his wife), the resident would be wise to visit an office equipment firm since many offer a free consulting and advisory service. Some will even furnish your entire office on the cuff—and at reasonable bank rates.

not exceed $40 for each table—unless you wish to use expensive period furniture. Lamp prices vary from just under $30 to nearly $60. The lower range offers an attractive and durable selection.

Consultation room

The consultation room can be kept simple and uncluttered by limiting the amount of furniture included. Carpeting on the floor adds dignity and together with drapes on the windows, contributes to the soundproofing of the room.

The major pieces of furniture are those for the urologist himself; a desk and chair. Since a great deal of time will be spent here alone by the urologist, the chair should be one which he has tried and found to his liking in both comfort and appearance. Desk chairs which tilt and rotate can cost from $70 to as much as $200. The main thing, however, is that it fit the urologist comfortably.

Desks vary in price from $75 to $400. The desk should fit the room, not fill it. All consultation room furniture should be in the same style. Other than the physician's own chair, one chair will be provided for the patient (cost $40-$75) and another for a friend or relative of the patient. These, too, should be comfortable so that a lengthy history-taking session doesn't unduly tire the patient.

Bookcases have a double advantage in the consultation room. They are decorative in themselves, and they provide a storage space for much of the clutter that often finds its way to the top of the specialist's desk. (This last point is of more importance than you may suspect. A sloppy, unkempt desktop often gives the patient the impression that the physician is confused and disorganized—hardly a good impression for any physician to give to a present or prospective patient.)

Attractive bookcases are not cheap, whether bought ready-made or custom made. However, used bookcases of good quality can be purchased at a considerable saving. Built in bookcases offer an excellent way to utilize odd-sized wall areas, but here too, expense is a big factor —unless you happen to be fortunate

enough to have a carpenter or cabinet-maker as a patient.

The majority of urologists surveyed had a viewbox in the consultation room. A large number of the urologist's patients are referred and bring x-rays with them on the first visit which must be read by the urologist. A new viewbox will cost from $25 to $150, depending upon construction and the number of frames.

Cystoscopy room

The average urologist has two examining rooms; one for cystoscopy and one for routine physicals. The major piece of equipment in the cysto room is the cystoscopy table. A simple table can be purchased or one which combines an x-ray unit for retrogrades and intravenous pyelograms.

Table and x-ray

The majority of urologists reporting (70%) stated they had purchased an x-ray unit immediately upon entering private practice. Most of this group felt that the unit pays for itself soon enough to justify its purchase at the beginning.

One reported: "You can't consider yourself a urologist without an x-ray for IVPs and retros—you would be more nearly practicing internal medicine rather than urology."

The minority who stated they did not purchase an x-ray immediately gave the high cost as a reason for deferring this piece of equipment.

A new cysto table without x-ray may cost as much as $1200. A used table in good condition will be from $150 to $350. The required x-ray unit (100 ma.) will cost from $1200 to $2000. Darkroom equipment and plumbing must also be added to this cost. Average cost of darkroom equipment with a five gallon tank ran under $200 for the surveyed group of urologists, excluding plumbing.

In addition to the table, an irrigation stand will be needed. A complete unit including spotlight will cost from $100 to $150. It will cost less for a wall type unit without the stand. Two stools at about $20 each will complete the table unit grouping.

Cystoscope and cautery

Cystoscopes, of course, are required. The majority of urologists started in practice with two, each costing from $175 to $300.

Roughly a third of beginning urologists purchase an electric cautery. Prices paid averaged $450. The majority reported they did not have nor did they intend to purchase this piece of equipment. "Any required cauterization should be done in the hospital," according to one respondent.

Sounds, catheters

Varying sizes of sounds and catheters are required, of course. A complete set of ureteral catheters is needed. Average total outlay for

TWO STEPS TO SAVINGS

1. Consult an office equipment company which maintains an advisory staff having experience in equipping doctors' offices.

2. Make a tentative list of equipment items you think you'll need immediately — together with cost estimates.

this group was $125. Commonly found in the cysto room was a wall type viewbox in addition to the one located in the consultation room. Also, a medicine cabinet, average cost near $80, was reported by many practicing urologists.

Other equipment

Additional equipment reported by most urologists included those items needed for routine urinalysis, blood counts and sed rates. A centrifuge, if purchased new, will cost no more than $75. A new microscope will cost from $250 up; secondhand prices usually start at $125.

The average urologist preferred cold sterilization for catheters and sounds. But most indicated the need for a fourteen or sixteen inch sterilizer for instruments and syringes. Purchased new, such a sterilizer will cost in the neighborhood of $75.

Drugs and dye supplies will cost under $50. One point made by a number of respondents was that such items as adrenalin, cortisone and antihistamines should be on hand for the treatment of allergic reactions occurring in the office.

Second room

Many urologists have a second room for basic examinations. This can be equipped simply and at small cost. A suitable table can be purchased for as little as $100—or a standard examination table can be obtained at prices beginning at $250.

In this room can be located a scale. Cost will be between $50 and $75. In addition, a treatment stand and instrument cabinet can be installed as part of the examining room equipment. Illumination can be from a simple spotlight ($20) or a more elaborate overhead lamp costing up to $150.

Extra lavatory

According to many urologists, an additional lavatory, one which is not accessible from the waiting room, should be available to patients in the examining and cystoscopy rooms. Furnishing the lavatory with mirror, table, chair, disposal can, etc., should cost less than $50.

Printing

There are a number of incidental items which should be included in the office equipment budget. One of the most important of these, but often overlooked until the last minute, is "printing." This would include your announcements (to let the other doctors in your community

know you're in business), personal cards, letterheads, billheads, case records, bookkeeping forms, etc.

The total expenditure you can expect to make for this type of necessary professional printing will be about $60. There are firms which make a specialty of supplying doctors' printing needs. Quite often it will save you time and money to order your forms, stationery, and a bookkeeping system from these specialists. In most cases, you can make all such arrangements by mail.

Basic needs

The foregoing represents the basic needs of the beginning urologist, according to RESIDENT PHYSICIAN poll. The selection made in this discussion of essential equipment comprises an average estimation of that equipment which will be basically useful to the beginning practice. Prices in all cases are for new equipment and give only the approximate range for each category.

Many offices can be (and are) much more elaborately equipped. Also, special consideration was given to price. In modern day merchandising, credit terms can be made so attractive to the beginning practitioner that in many cases it may be wiser to purchase an income-producing item on credit, rather than to defer it.

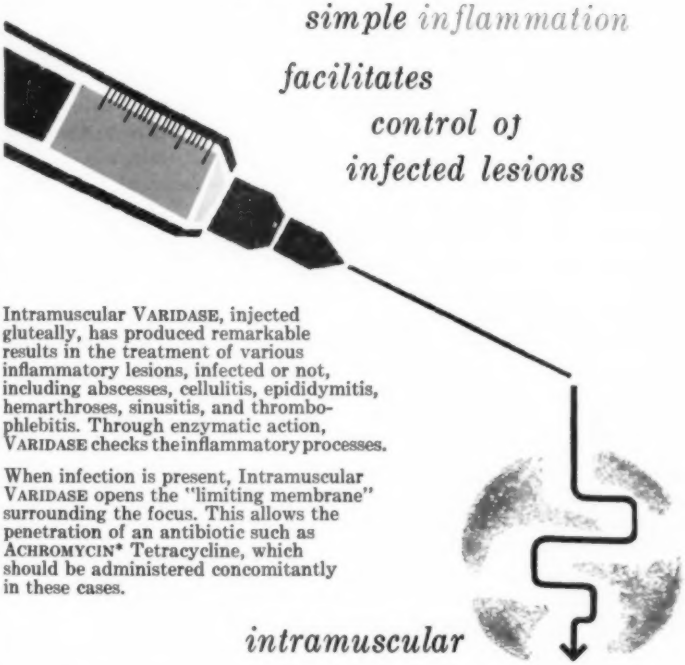
Average costs

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure was to be complete, but excluding such items as typewriters, nurse's desk, nurse's chair, filing cabinet, etc., some of which you may be able to do without.

About half of the urologists equipped their offices with an expenditure of less than $4000. Nearly 30% reported initial equipment purchases of $4000 to $5000. The remainder of the group spent between $5000 and $6000.

Reprints of this and previous articles in the series (Internist's Office, Ophthalmologist's Office, Pediatrician's Office, Surgeon's Office, and Ob-Gyn Office) now available from the publisher at 30 cents (in coin or stamps) for each copy.

quickly dissipates
simple inflammation
facilitates
control of
infected lesions



Intramuscular VARIDASE, injected gluteally, has produced remarkable results in the treatment of various inflammatory lesions, infected or not, including abscesses, cellulitis, epididymitis, hemarthroses, sinusitis, and thrombophlebitis. Through enzymatic action, VARIDASE checks the inflammatory processes.

When infection is present, Intramuscular VARIDASE opens the "limiting membrane" surrounding the focus. This allows the penetration of an antibiotic such as ACHROMYCIN* Tetracycline, which should be administered concomitantly in these cases.

intramuscular

VARIDASE*

Streptokinase-Streptodornase *Lederle*

Enzymatic Debridement. Used topically, VARIDASE quickly dissolves clotted blood and pus, speeds the growth of healthy granulation tissue in many kinds of wounds. Available in solution, or in a special jelly form which can easily be applied by the patient at home.

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*REG. U. S. PAT. OFF.

Psychiatry and Neurology Board Requirements

The American Board of Psychiatry and Neurology was organized in 1934 by the combined efforts of the American Psychiatric Association, the American Neurological Association and the Section on Nervous and Mental Diseases of the American Medical Association. The Board is composed of twelve members, four each from the American Neurological Association and from the American Psychiatric Association, two neurologists and two psychiatrists elected by the Section on Nervous and Mental Diseases of the American Medical Association.

Purposes

In brief the Board was set up to serve the following purposes:

1. Determine the competence of specialists in psychiatry and in neurology.

2. Arrange, control and conduct investigations and examinations to test the qualifications of voluntary candidates for certification issued by the Board.

3. Grant and issue certificates or other recognition of special knowledge in the field of psychiatry and neurology.

4. Serve the public, physicians, hospitals and medical schools by preparing lists of practitioners who shall have been certified by the Board.

5. Consider and advise as to any course of study and technical training, and to diffuse information to promote the fitness of persons desiring to qualify for a certificate of qualifications.

Basic requirements

Each applicant for a certificate must establish that:

1. He is a physician duly licensed by law to practice medicine.

2. He is of acceptable ethical and professional standing.

3. He is now a member of the American Medical Association. (Exceptions may be made at the discretion of the Board.)

4. He has received adequate training in psychiatry or neurology (or both) as a specialty.

Special education

Medical Education and Hospitals of the American Medical Association. In the case of an applicant who re-

1. Graduation from a medical school in the United States or Canada approved by the Council on ceived medical training outside the United States and Canada, such training must be satisfactory to the Council.

2. Completion of one year of internship approved by the Council in general medicine, general surgery, pediatrics or a rotating service. (The nine-month wartime internships will be accepted as an equivalent of one year.)

3. Three years of specialized training in approved training centers plus two years of experience.

Training required

Admission to the examination for certification in both psychiatry and neurology requires a total of six calendar years of training and experience, five years of which must be specialized training obtained in approved training centers, plus one year experience. The specialized training may be subdivided into two and one-half years each in psychiatry and neurology or three years in one subject and two years in the other. The required year of experience should be spent in clinical practice with major responsibility for the care of patients.

Candidates seeking certification in both neurology and psychiatry, or supplementary certification in one after being certified in the other, must submit evidence satisfactory to the Board of an additional two years of full-time basic training in the supplementary specialty.

Thus, no candidate is eligible for examination by the Board until he has completed at least five years of special training and experience in neurology or in psychiatry for a single certificate, or at least six years of special training and experience in neurology and psychiatry for certification in both.

Credit

The Board will give not more than six months credit for not less than six months of training in an approved training center for internal medicine or pediatrics, in lieu of six months of experience, to candidates for the certificate in psychiatry or neurology but not to candidates

for certification in both psychiatry and neurology.

The Board will give credit for one year of training in child psychiatry providing it is the third year of the required three years of special training required and providing it is taken in a center approved by this Board for training in child psychiatry.

After July 1, 1956, training credit for work in the field of child psychiatry may be gained only by participation in a hospital residency training program that is regularly approved. After that date, all independent training approval of psychiatric clinics for children is discontinued.

Applicants who graduated from an approved medical school before 1934 will not be held to the strict interpretation of the published requirements in formal graduate training.

Under such circumstances the Board will consider the training and experience of the applicant and decide whether or not he will be admitted to the examinations. For such graduates, the Board will consider ten years of full-time acceptable experience in psychiatry or neurology in lieu of the formal training requirements. Should the candidate then apply for supplementary certification, the Credentials Committee will require five years of additional acceptable experience taken in the supplementary field.

Military service

Credit will be granted for one year of wartime military service (December 7, 1941 to February 15, 1946) in the Army, Navy, Public Health Service and Veterans Administration. Further credit for specialized training will be granted only if the candidate has received training in an institution recognized by the Council on Medical Education and Hospitals of the American Medical Association and approved by this Board. Time beyond one year spent in the above Government agencies may be credited to experience providing the candidate has been regularly assigned to a service in neurology or psychiatry.

Under certain conditions, training and experience credit toward requirements for examination will be granted for military duty during the present emergency. This policy relates to active military medical duty since July 1, 1950. One year of training credit will be granted for

one year spent in full-time psychiatric and/or neurological duties. Additional training credit will be granted for that amount of time spent in approved training programs. Experience credit will be granted for any remaining time spent in full-time psychiatric and/or neurological assignments. Double credit will not be granted for any single period of time.

For military duty after January 1, 1954, only experience credits will be granted for full-time psychiatric and/or neurologic duties. Training credit will be granted for residency assignments in regularly approved training programs.

Application and fees

An application, in order to be considered by the Board, must be in the hands of the Secretary of the Board not less than *ninety days before the date of examination.*

Application may be made for certification in psychiatry or neurology, or in both fields.

The candidate upon filing his application shall accompany it with an application fee of $35, which is not returnable. If a preliminary written examination has been decreed, an additional $25 fee will be required at the time of the applicant's acceptance. When notified by the Secretary that he is accepted for the oral and practical examination, the candidate shall send to the Secretary an examination fee of $65. A candidate who has been certified in either psychiatry or neurology and who has been admitted to supplementary examination for the other certificate shall pay an additional examination fee of $65.

Re-examination

A candidate who has failed in one examination is eligible for re-examination within one year upon payment of a re-examination fee of $50. After the year has elapsed he must submit a new application and pay new application and examination fees. If he fails the re-examination, he may, after two years have elapsed, submit a new application and $35 fee, present evidence of further training, and pay an examination fee of $65.

A candidate who fails in one or two subjects is eligible for re-examination in those subjects within one year and upon payment of a re-examination fee of $50. After the year has elapsed he must submit a new application and pay new ap-

plication and examination fees and repeat the entire examination. If he fails the re-examination, he may apply again for the complete examination after two years upon submission of evidence of further training and upon payment of an application fee of $35. If admitted to the examination, he must pay a new examination fee of $65.

Any candidate who finds himself unable to attend an examination to which he has been admitted and does not notify the Secretary at least six (6) weeks before the date of the examination will forfeit his examination fee. Any candidate who fails to appear for examination within a period of three (3) years following the date of notification of eligibility for examination is required to submit a new application and pay the attendant fee.

Examination

Though the purpose of the examination is to test the competence of the candidate in psychiatry or neurology or both, it must not be forgotten that both these medical disciplines constitute part of the broad field of general medicine. The Board requires some proficiency in neurology on the part of those it certifies in psychiatry and vice versa, but examines the candidate in accordance with the certificate he seeks. The examinations will be such that no adequately trained person will fail.

The practical examination includes the examination of patients under the supervision of the examiner. The manner of examining patients, and the reasoning and deductions therefrom, constitute an important part of the examination.

Oral and practical examinations are given in the basic sciences with special regard to their clinical implications. While the examination is oral, a written examination may be given at the discretion of the Board. The examination for certification in psychiatry will differ from the examination for certification in neurology.

The examination consists of six, one-hour examination sessions. Examinations are given in different cities throughout the country and are either two or three in number each year.

Grades

The results of the examination are mailed to each candidate on the final night of the examination. No actual grades are given but the candidate either passes, fails, or receives a condition. If the candidate fails the entire examination, it is necessary to repeat the entire examination. If a condition in only one or two subjects is received, only this part of the examination need be repeated.

Certificates

Separate certification will be given in psychiatry and in neurology and a combined certification for those qualified in both fields.

Further information

Information may be obtained by writing to David A. Boyd, Jr., M.D., Secretary - Treasurer, American Board of Psychiatry and Neurology, 102-110 Second Ave., S.W., Rochester, Minn.

Going To Chicago?

All residents and interns attending the A.M.A. Convention in Chicago (June 11 to 15) are cordially invited to visit the RESIDENT PHYSICIAN exhibit. Article reprints will be available. Besides providing you with a place to sit down for a breather amidst the Convention hustle, we will have a message service to help you locate your colleagues.

We would also like you to sign our "Resident Register" and let us snap your picture for a later issue of your journal. Our Editor-in-Chief, Perrin H. Long, M.D., will be on hand to greet you.

So write your physician friends now. Tell them you'll leave a note at the RESIDENT PHYSICIAN exhibit letting them know where you'll be staying while in Chicago.

Mediquiz

Question are from a civil service examination given to candidates for physician appointments in municipal government.

Answers on page 130.

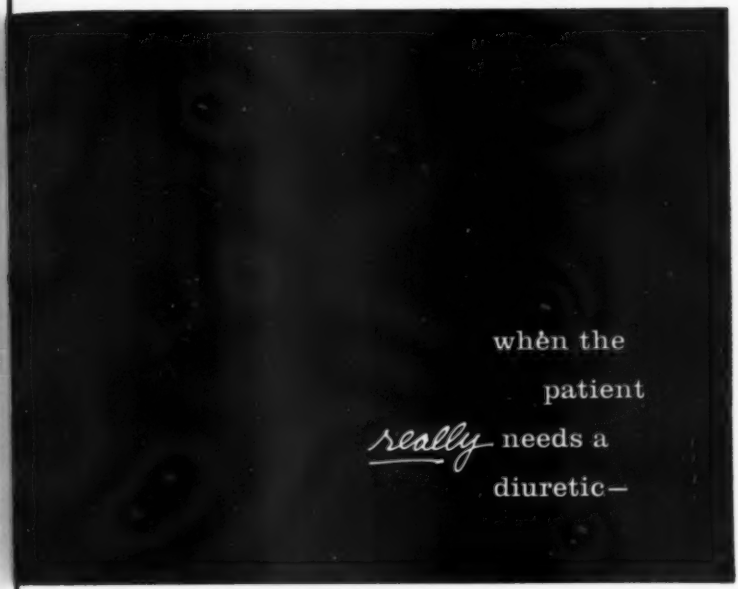
1. The most convenient formula for estimating blood or blood substitute replacement in a burned patient in the first 48 hours is based on: (A) hematocrit and hemaglobin determinations; (B) blood volume determination; (C) percent of burned surface; (D) body weight and percent of burned surface.

2. A healthy, 37-year-old male was involved in an auto accident when the car he was driving collided head on with another car. Due to the impact he was thrown forcibly against the steering wheel and received a considerable blow to the left lower thoracic cage and upper abdomen. He is hospitalized and except for some tenderness in the contused area, findings are negative. X-rays of chest and abdomen are negative. The patient is kept under observation for three days, becomes asymptomatic and is discharged home. Seven days after discharge, he is readmitted in profound shock, with complaints of pain in the left upper and left lower quadrants. His blood count, hematocrit and blood pressure indicate profound loss of blood. The most likely diagnosis is: (A) massive hemorrhage from bleeding ulcer; (B) hemothorax; (C) delayed hemorrhage from rupture of the spleen; (D) ruptured viscus.

3. Of the following methods of artificial respiration, the one which has been shown to produce the highest volume of pulmonary ventilation is: (A) prone, back-pressure (Schafer); (B) arm-lift, chest-pressure (Silvester); (C) end-rocking; (D) hip-lift, back pressure.

4. Of the following, the one which is not a lipotropic agent is: (A) methionine; (B) choline; (C) acetylcholine; (D) inositol.

5. In the dietary management of decompensated Laennec's cirrhosis of the liver, the one of the following which is preferred is a high caloric diet containing: (A) carbohydrates,



E NEEDS AN ORGANOMERCURIAL

those patients with borderline or very mild congestive heart failure who can even along without diuretic therapy, any agent producing minimal or intermittent resis may appear to produce benefit.

when cardiac decompensation—mild, moderate, or severe—is established, depend- and continuously effective diuresis—obtainable only with potent oral organomer- ials—is a therapeutic necessity.

TABLET
NEOHYDRIN®
BRAND OF CHLORMERODRIN (10.2 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

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a standard for initial control of severe failure
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protein, fats, supplemented with B-vitamins and restricted in sodium chloride; (B) carbohydrates and protein, supplemented with B-vitamins but devoid of fats, with no sodium chloride restriction; (C) carbohydrates and fats, restricted in protein and sodium chloride, supplemented with B-vitamins; (D) protein and fats, supplemented with B-vitamins, restricted in carbohydrates, with no sodium chloride restriction.

6. In advanced Laennec's cirrhosis of the liver, the characteristic alteration of the serum protein is: (A) fall in serum albumin, rise in serum globulins; (B) fall in serum albumin and globulins; (C) fall in serum albumin, normal serum globulins; (D) rise in serum albumin, fall in serum globulins.

7. Portacaval shunts are of greatest therapeutic value in relief of: (A) ascites; (B) gastro-intestinal bleeding from portal hypertension; (C) jaundice; (D) cavernous transformation of the portal vein.

8. Of the following disturbances the one most rarely associated with hepatic insufficiency is: (A) salt-water retention; (B) hyperuricemia; (B) hypo-albuminemia; (D) hypocholesteremia.

9. Bilirubinate stones occur most frequently in: (A) obese middle-aged women; (B) typhoid convalescents; (C) spherocytic anemia patients; (D) familial hyper-bilirubinemia patients.

10. A 17-year-old male is involved in a bus accident. Besides multiple contusions and abrasions, his chief injury is found to have been sustained on the right lower leg. Here the entire thickness of the skin and subcutaneous tissue has been torn away from its attachment just below the knee and rolled down like a stocking to the ankle by an avulsion injury. At the ankle, the skin is attached all around. There are no fractures nor other soft tissue injuries. The treatment of choice at debridement should be to: (A) detach the avulsed skin and cover the denuded area with split skin grafts; (B) detach and replace subcutaneous tissue without removing it; (C) leave the skin attached at the ankle, unfold and replace it with sutures; (D) detach the entire skin, scrape off all subcutaneous tissue and fat and replace it as a graft.

11. Azotemia in glomerulonephritis is predominantly a consequence of: (A) renal edema; (B) decreased maximal tubular excretory capacity; (C) reduction of glomerular filtration; (D) tubular back diffusion.

12. The volume of extracellular water may be measured by determining the dilution of a known amount of injected: (A) sodium thiosulfate; (B) Evans Blue; (C) antipyrine; (D) deuterium oxide.

13. Hematuria and costovertebral angle pain are prominent features of: (A) chronic diffuse glomerulonephritis; (B) polycystic disease of the kidneys; (C) cystitis; (D) prostatitis.

14. The presence of left axis deviation in an otherwise unremarkable electrocardiogram is: (A) always indicative of left heart enlargement; (B) diagnostic of myocardial disease; (C) always found in hypertensive heart disease; (D) without significance.

15. The one of the following conditions in which cyanosis is not usually due to arterial blood oxygen unsaturation is: (A) chronic cor pulmonale; (B) tetralogy of Fallot; (C) congestive heart failure due to arteriosclerotic heart disease; (D) Eisenmenger's complex.

16. Of the following blood vessels, the one which most commonly causes persistent hemorrhage following a penetrating or perforating wound of the thorax is: (A) pulmonary; (B) internal mammary; (C) bronchial; (D) intercostal.

17. Of the following procedures, the one which you should rely upon most for diagnosis of a solitary lesion in the periphery of the lung discovered by x-ray is: (A) Papanicolaou smear of bronchial secretions; (B) thoracotomy; (C) tomography; (D) bronchoscopy.

What's the Doctor's Name?

James Gallagher

He was born on November 12, 1867, in Choyhung, China, about forty miles from Canton and thirty miles north of Macao.

In 1886, he entered Pok Tsai Medical School in Canton and, in 1887, he transferred to the newly founded Alice Memorial Hospital in Hong Kong. He was the first pupil to enroll and one of the first to graduate.

He received the certificate of proficiency in medicine and surgery in 1892, the same year he founded a hospital in Macao, which was later transferred to Canton.

Caught up in China's discontent, he became a revolutionary. In 1896-97 and in 1904-05 he visited the United States and Europe, lecturing and collecting funds.

An exciting event in his travels was his kidnapping by Manchu agents in London in 1896. During his second visit to the United States he studied and was influenced by Lincoln's life. "Government of the people, by the people, for the people" became the watchword of the Chinese Revolution, first in the rendering of "The people are to have, the people are to rule, the people are to enjoy," and later in the pronouncements of the Three Principles: nationalism, democracy, and livelihood.

After ten unsuccessful revolutionary attempts at Canton, the eleventh at Wuchang was successful and on December 29, 1911, he was elected provisional president of the Republic. (He resigned February 14, 1912 in an effort to unite all China.)

In 1914 he married his second wife, the sister of Madame Chiang Kai-Shek.

In 1917 he was elected generalissimo and in 1921 president. Both the Chinese Communists and Nationalists claim him. He died February 24, 1925 and was buried near Peking.

Can you name this doctor without turning to page 130?

Leads and Needs

OFFICE SPACE

MIRACLE MILE, MANHASSET, LONG ISLAND, NEW YORK: 1000 square feet air conditioned office space. 1445-7 Northern Boulevard, Manhasset, New York. Directly opposite Lord & Taylor. Convenient parking space in rear of building. Within 10 minutes of five hospitals. Walking distance to railroad station. Bus service passes door. Would prefer to rent as single unit to group, but will consider a few individual units. $5.00 per square foot.
If interested, write Romaine Pierson Publishers, Inc., 676 Northern Blvd., Great Neck, N. Y.

RESIDENTS WANTED

GENERAL RESIDENT WANTED (house physician) for July 1, 1956; Salary $350 per month and maintenance, general hospital with 312 beds and 36 bassinets; must be licensed in Pennsylvania. Apply: D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

SUMMER IN MAINE—Leading boy's camp; licensed physician for July and August; consider two doctors. 1 each month; interview New York or Boston area. Reply: Camp Menatoma, Kents Hill, Maine.

PATHOLOGY RESIDENT—Opening for first, second or third year in 250 bed university hospital, approved 3 years. Full maintenance plus $225 monthly to start. J. C. Sherrick, M.D. Grant Hospital, Chicago 14, Illinois.

MEDICAL RESIDENCY—Openings July 1, 1956, in 1st, 2nd and 3rd year program of fully approved three-year Residency in Internal Medicine; 800-bed University-affiliated county general hospital. Apply: L. A. West, M.D., Medical Director, Los Angeles County Harbor General Hospital, 1124 West Carson Street, Torrance, California.

PHYSICIAN—staff associate; private psychiatric hospital in beautiful Finger Lakes region of New York State; full maintenance for couple available; salary commensurate with experience and training. Contact: Brigham Hall Hospital. Canadaigua, New York.

ANESTHESIOLOGY RESIDENCIES—University of Utah and affiliated hospitals, 1st year and 3rd year available now and July 1st. Active teaching program; excellent salary; fully approved. Contact: Carter M. Ballinger, M.D., Division of Anesthesiology, University of Utah, Salt Lake City, Utah.

PSYCHIATRISTS, PSYCHIATRIC RESIDENTS, and general physicians—Indiana's most progressive mental health program; assistant superintendents, clinical directors, chiefs of service, $11,700-$14,700; psychiatrists, $9,300-$12,900; psychiatric residents, $4,380-$5,740; general physicians, $6,900-$9,900; U. S. citizenship and Indiana license required. Write: Division of Mental Health, 1315 West 10th Street, Indianapolis 7, Indiana.

PSYCHIATRIC RESIDENCIES—Indiana University Medical Center; are now available; fully-approved for 3 years of psychiatric training in a modern 2500 bed medical center; widely diversified training and experience provided in a 250 bed psychiatric treatment hospital, under Dr. D. F. Moore with rotating services through adjacent campus facilities, including 500 bed Veterans Administration hospital with Dr. E. G. Gogel, Chief of Neuropsychiatry, active university child guidance clinic and a university psychiatric outpatient clinic; ample opportunities for training and consultative services in a variety of university clinics and in 3 other university hospitals, including a children's hospital; broadly oriented university training program with close personal supervision of psychotherapy in clinics and hospitals; impressive interdepartmental opportunities for active clinical and allied basic research in a new psychiatric research institute and for teaching and supervisory experience in the medical school and its affiliated training programs in the social sciences; stipend for 1st year, $4380, increasing proportionately to 3rd year $5760; eligibility for state licensure required for appointment. Write: J. I. Nurnberger, M.D., Department of Psychiatry, Indiana University Medical Center, Indianapolis, Indiana.

ROTATING RESIDENCIES—general practice available July 1, 1956; salary $400 per month; must be citizen; 100 bed hospital; well-equipped and with full accreditation on Joint Commission. Write: Administrator, Tulare County General Hospital, Tulare, California.

APPROVED RESIDENCIES—VA Hospital; integrated programs, Baylor University Affiliated Hospitals, Texas Medical Center. Vacancies Internal Medicine, Neurology, Ophthalmology, Otolaryngology, Pathology, Physical Medicine, Psychiatry and Urology; $2840-$3550. Career residencies Neurology, Psychiatry and Physical Medicine; $5915-$8990. Manager, VA Hospital, Houston, Texas, or Dean, Baylor University College Medicine, Texas Medical Center.

COMMUNITY HOSPITAL (small) needs additional doctor; training in internal medicine desirable. Write: Griggs Community Hospital Association or to Dr. Wakefield, Cooperstown, North Dakota.

OPPORTUNITIES AVAILABLE IN VIRGINIA—For vacancies to be created by retirements beginning March 1, 1956. (1) Two assistant directors of local health departments; applicants without public health training or experience given on-the-job training and paid a beginning salary of $8400; must be under 38. (2) Two directors of local health departments; salary $9600 to $11,472; must be under 50 with recognized public health training experience; applicants must be American citizens and eligible for Virginia licensure; liberal sick leave, vacation, and retirement benefits. Write: Director of Local Health Services, State Department of Health, Richmond 19, Virginia.

APPROVED RESIDENCIES—Internal Medicine available quarterly, Veterans Administration Center, Dayton, Ohio; 3-4 year program. Citizenship required. Affiliated and supervised by Ohio State University Medical School. Salary $2840-$3550 per year. Approved for benefits under Public Law 550. Apply: Dr. S. Simerman, Chief Medical Service, VA Center, Dayton, Ohio.

HOUSE PHYSICIANS WANTED; 345 bed general hospital; rotating service; $200 month, room and board furnished; must speak fluent English; apply immediately for July 1st appointment. Kentucky Baptist Hospital, Louisville, Kentucky, H. L. Dobbs, Administrator.

FELLOWSHIPS—available; approved in Anesthesiology, medicine, surgery and other specialties; stipend $200. Ochsner Foundation Hospital, New Orleans 21, Louisiana.

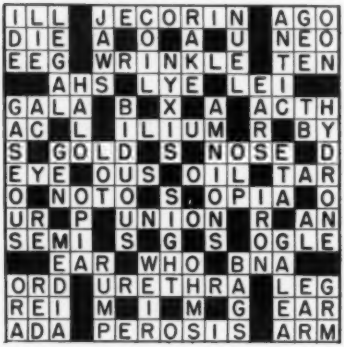
GENERAL PRACTICE—Residents wanted for 238 bed county general hospital 25 miles from San Francisco. Approved for G.P. by A.M.A. Excellent teaching program. $300 plus maintenance. Dr. J. Paul Sweeney, 210 39th Avenue, San Mateo, California.

ANESTHESIOLOGY RESIDENCY; approved two year residency; integrated with other teaching programs, available July 1, 1956, maintenance and stipend. Apply to: Daniel C. Moore, M. D., Director of Anesthesia, The Mason Clinic and Virginia Mason Hospital, Seattle, Washington.

RADIOLOGY RESIDENCIES AVAILABLE — Veterans Administration Hospital; large 2000 bed General Medical and Surgical Hospital, fully approved for three years' training; citizenship required. Apply: Chief, Radiology Service, Veterans Administration Hospital, Hines, Illinois.

RESIDENT RELAXER

(puzzle on page 15)



WHAT'S THE DOCTOR'S NAME?

(from page 126)

(The doctor is Sun Yat-Sen.)

VIEWBOX DIAGNOSIS

(from page 17)

SIMPLE CYST

Simple cyst with healed pathological fracture. This is a very common site for these simple cystic bone lesions. Note expansion, radiolucencies and few trabeculations.

"MEDIQUIZ" ANSWERS

(from page 122)

1(D), 2(C), 3(B), 4(C), 5(A), 6(A), 7(B), 8(B), 9(C), 10(D), 11(C), 12(A), 13(B), 14(D), 15(C), 16(D), 17(B).

Sick patients need food for therapy

THAT MAN MUST EAT to remain well is a concept as old as medicine. But only recently has it been established (1) that nutritional needs are increased in illness; (2) that food sufficient to meet these needs is well utilized, and (3) that therapeutic nutrition prevents many of the debilitating effects of disease and injury.

Unfortunately, because of the anorexia accompanying illness, effective nutritional therapy requires added care on the part of the physician. Food comes from familiar kitchens and lacks the impressive aura of more dramatic therapeutic agents. Thus it is often difficult to convince the patient that food, too, is therapeutic—that although drugs may arrest disease only food can repair the ravages of disease.

Whatever the nutritional problem—whether caused by anorexia, mechanical difficulty in eating or limitation of gastric capacity or tolerance—only an assured food intake will solve it. The use of Sustagen, a food formulated for therapeutic nourishment, will overcome many difficulties in the therapeutic feeding of sick patients. A foundation for therapy thus may be established.

The development of Sustagen exemplifies the continuous effort of Mead Johnson & Company to provide the medical profession with products basic to the management of illness and the restoration of health.

Sustagen

Therapeutic Food for Complete Nourishment

Sustagen® is the only single food which contains all known nutritional essentials: protein, carbohydrate, fat, vitamins and minerals. It may be given by mouth or tube as the only source of food or to fortify the diet in brief or prolonged illness.

Sustagen

repairs tissue
restores appetite
overcomes asthenia

in

cirrhosis
peptic ulcer
geriatrics
infections
trauma
chronic disease

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